DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Today's Webinar is:

Treating Depression in Primary Care

May 24, 2012

1-2:30 p.m. (EDT)

DVBIC
Defense and Veterans Brain Injury Center

DHCC
Deployment Health Clinical Center

National Center for Telehealth & Technology

DEFENSE CENTERS OF EXCELLENCE
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Treating Depression in Primary Care

DCoE Monthly Webinar, May 24, 2012

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Additional Webinar Details

- The following continuing education units (CEUs) and continuing medical education (CME) credits are approved for this activity:
  - 1.5 AMA PRA Category 1 Credits™
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  - Visit **dcoe.health.mil/webinars**
- Question-and-answer session
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Agenda

- Welcome and Introduction
- Presentations
  - Anne C. Dobmeyer, Ph.D., ABPP
    - Screening and Assessment of Depression in Primary Care
  - Michael C. Freed, Ph.D.
    - Treating Depression in Military Primary Care Settings
- DCoE Resource Highlight
  - Lt. Col. Philip A. Holcombe, Ph.D.
    - Major Depressive Disorder Clinical Support Tools
- Question-and-answer session/discussion

Webinar Overview

Treating Depression in Primary Care

- Depression is a common medical condition impacting approximately 10 percent of Americans in a given year.
- Depression accounts for one of every five visits to primary care settings and is associated with various types of chronic illness (e.g., diabetes, heart disease, HIV, cancer), pain conditions and neurological disorders.
- Primary care settings offer an opportunity for early identification and intervention.
- Research suggests that primary care settings, which incorporate screening, treatment and symptom monitoring of patients, are likely to improve patient care.
- This webinar will discuss the prevalence of depression, screening tools and interventions that can be used by health care providers treating patients in primary care settings.

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Screening and Assessment of Depression in Primary Care

Anne C. Dobmeyer, Ph.D., ABPP

Cmdr., U.S. Public Health Service
Chief Psychology Consultant, Patient-Centered Medical Home
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Required Disclosure

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Disclaimer

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Overview

- Rationale for depression screening in primary care
- Key players and key tasks
- Screening measures
- Administrative and clinical processes
- Training
- Quality assurance

Why Screen for Depression?

- Depression is a cause of:
  - Decreased quality of life
  - Lowered productivity
  - Increased mortality

Why Screen for Depression?

- **Lifetime prevalence rates** (Kessler, et al., 2005)
  - Major Depression Disorder (MDD): 16.9 percent
  - Any mood disorder: 21.4 percent
- **MDD in military**
  - 5.1 percent of active-duty women, 2.8 percent of active-duty men (Riddle, et al., 2008)
  - 8-15 percent of returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans (Hoge, et al., 2004)

Why Screen for Depression in Primary Care?

- Prevalence of significant depressive symptoms ranges from 10-30 percent in primary care settings (McQuaid, et al., 1999; Stein, et al., 1995)
- Depression is under-recognized by primary care providers (PCPs) in two-thirds of patients (Coyne, et al., 1995; Nisenson, et al., 1998)

Why Screen for Depression?

- **U.S. Preventive Services Task Force: (May 2002)**
  - Routine depression screening is important for reducing morbidity and mortality
- **VA/DoD Clinical Practice Guideline: (May 2009)**
  - Annual screening for MDD in primary care
  - Use standardized screening tools

Why Screen for Depression in Primary Care?

"Depression is common, underdiagnosed, and undertreated."

(VA/DoD CPG, 2009)

Implementation of Primary Care Depression Screening

- **Key Players for Implementation**
  - Clinic leadership
  - PCP representative
  - Nursing representative
  - Admin representative
  - Behavioral health asset, if present

Implementation of Primary Care Depression Screening

- Key Tasks
  - Identify treatment and referral options
  - Determine screening frequency
  - Select screening and assessment measures
  - Develop administrative/clinical processes
  - Develop training plan
  - Develop quality assurance plan

Selection of Measures

- **Patient Health Questionnaire (PHQ)-2**
  - Brief screener for depression
  - Two items
  - Total score 0-6
  - Consider cut score of "3" for balance between sensitivity and specificity (Kroenke, Spitzer, & Williams, 2003)

PHQ-2

- Over the past two weeks, how often have you been bothered by any of the following problems?
  - Little interest or pleasure in doing things
    - ☆ 0 = not at all
    - ☆ 1 = several days
    - ☆ 2 = more than half the days
    - ☆ 3 = nearly every day
  - Feeling down, depressed or hopeless
    - ☆ 0 = not at all
    - ☆ 1 = several days
    - ☆ 2 = more than half the days
    - ☆ 3 = nearly every day

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PHQ-2 Scores and Depressive Disorder Probability (Kroenke, et al., 2003)

PHQ-2 Score	Probability of MDD (%)	Probability of Any Depressive Disorder (%)
1	15.4	36.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

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Selection of Measures: PHQ-9 as Diagnostic Aid

- PHQ-9
  - Nine items, including suicide item (#9)
  - Plus, question on functional impairment
  - Adequate performance in medically ill patients
  - Use with caution with patients older than 75 years

PHQ-9

- Can yield info for provisional diagnosis
- Sum of items yields severity score

Severity	PHQ-9 Score	Initial Strategy
None	0-4	N/A
Minimal	5-9	Support; educate to call if worsens; monitor as needed
Mild	10-14	Consider treatment -- Therapy or medication, or -- Both
Moderate	15-19	
Severe	20-27	Recommend therapy AND medication

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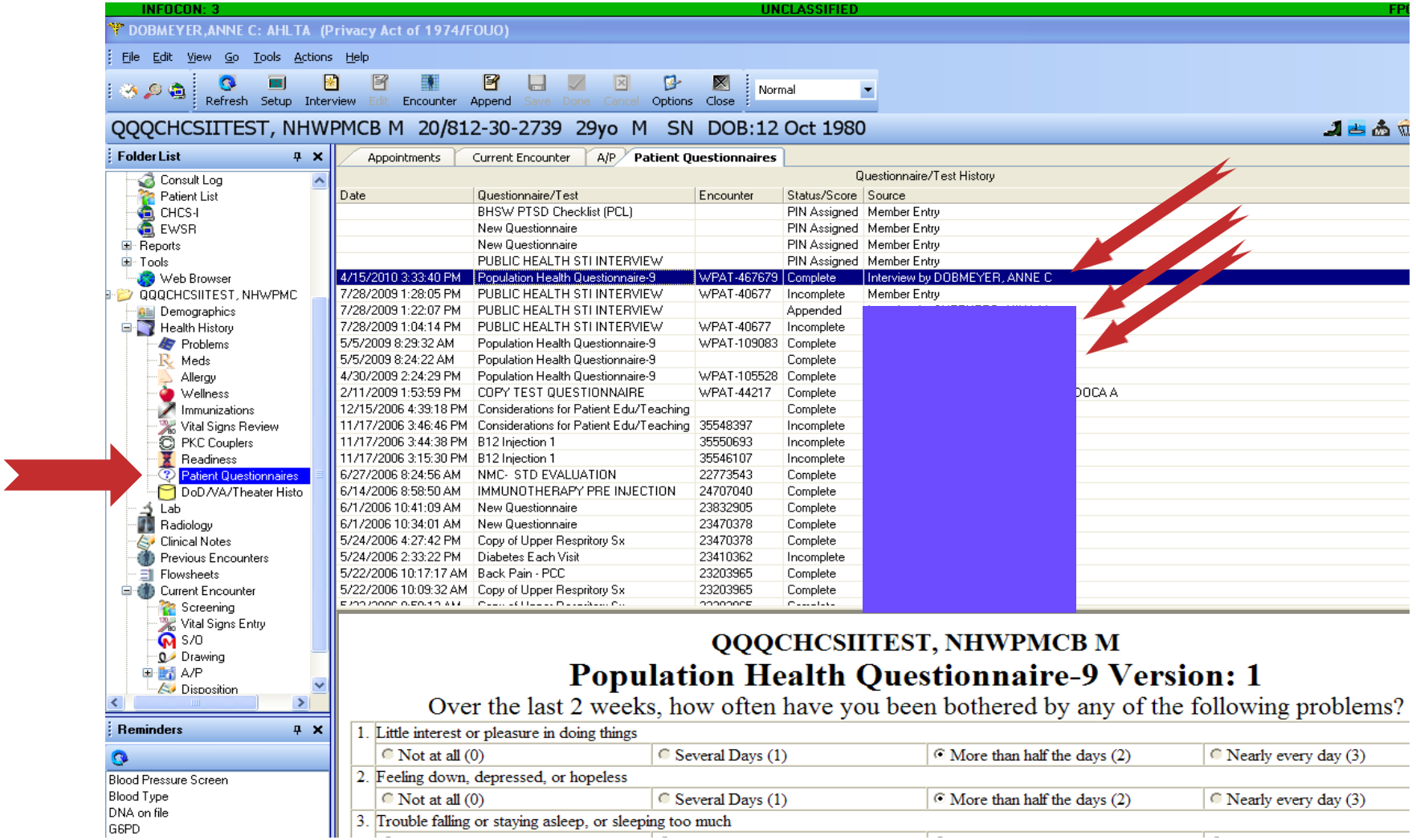
Administrative & Clinical Processes: *Example*

- Frequency of screening
  - Every patient, every visit
- Given PHQ-2 at check-in
  - Patient completes written form in waiting area
  - Administrative staff scores and enters results in electronic medical record (EMR)
- If score > 3, given PHQ-9
  - Patient completes PHQ-9; gives to nurse
  - Nurse enters results in EMR and alerts PCP

PHQ-9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Lab
Radiology
Clinical Notes
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Flowsheets
Current Encounter
Screening
Vital Signs Entry
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Blood Type
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New Questionnaire PIN Assigned Member Entry
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4/15/2010 3:33:40 PM Population Health Questionnaire-9 WPAT-467679 Complete Interview by DOBMEYER, ANNE C
7/28/2009 1:28:05 PM PUBLIC HEALTH STI INTERVIEW WPAT-40677 Incomplete Member Entry
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6/27/2006 8:24:56 AM NMC- STD EVALUATION 22773543 Complete
6/14/2006 8:58:50 AM IMMUNOTHERAPY PRE INJECTION 24707040 Complete
6/1/2006 10:41:09 AM New Questionnaire 23832905 Complete
6/1/2006 10:34:01 AM New Questionnaire 23470378 Complete
5/24/2006 4:27:42 PM Copy of Upper Respritory Sx 23470378 Complete
5/24/2006 2:33:22 PM Diabetes Each Visit 23410362 Incomplete
5/22/2006 10:17:17 AM Back Pain - PCC 23203965 Complete
5/22/2006 10:09:32 AM Copy of Upper Respritory Sx 23203965 Complete
QQQCHCSIITEST, NHWPMCB M
Population Health Questionnaire-9 Version: 1
Over the last 2 weeks, how often have you been bothered by any of the following problems?
1. Little interest or pleasure in doing things
Not at all (0) Several Days (1) More than half the days (2) Nearly every day (3)
2. Feeling down, depressed, or hopeless
Not at all (0) Several Days (1) More than half the days (2) Nearly every day (3)
3. Trouble falling or staying asleep, or sleeping too much

Administrative & Clinical Processes: *Example*

- **PCP roles:**
  - Reviews PHQ-9
  - Conducts interview, determines diagnosis
  - Assesses and manages risk
  - Develops initial treatment plan with patient
    - ☆ Medication and/or
    - ☆ Referrals
      - ○ Behavioral health consultant (internal)
      - ○ Behavioral health case manager (internal)
      - ○ Specialty mental health provider (external)
      - ○ Other (external)

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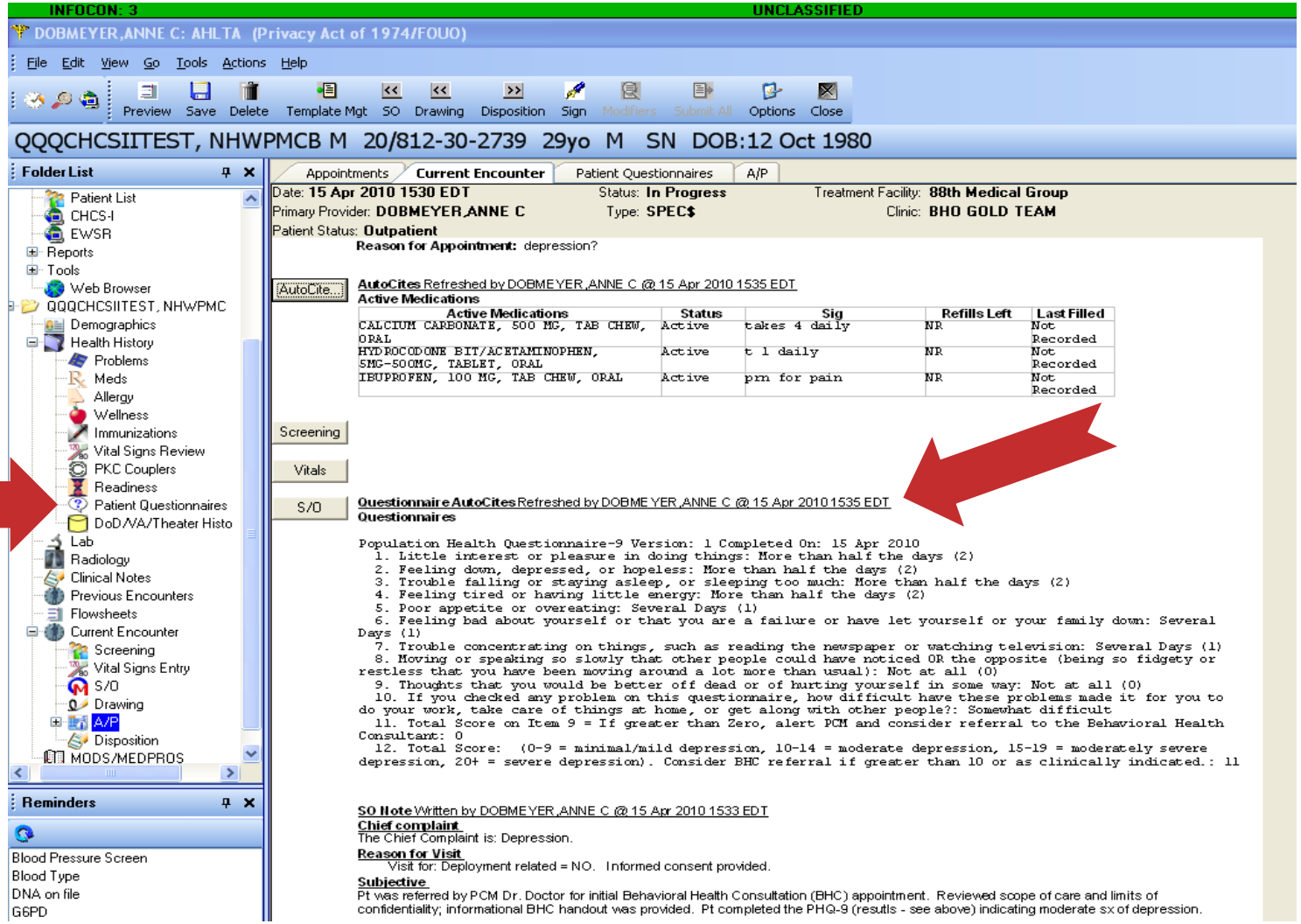
PHQ-9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Radiology
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Previous Encounters
Flowsheets
Current Encounter
Screening
Vital Signs Entry
S/O
Drawing
A/P
Disposition
MODS/MEDPROS
Reminders
Blood Pressure Screen
Blood Type
DNA on file
G6PD
Appointments
Current Encounter
Patient Questionnaires
A/P
Date: 15 Apr 2010 1530 EDT
Status: In Progress
Treatment Facility: 88th Medical Group
Primary Provider: DOBMEYER,ANNE C
Type: SPEC$
Clinic: BHO GOLD TEAM
Patient Status: Outpatient
Reason for Appointment: depression?
AutoCite...
AutoCites Refreshed by DOBMEYER,ANNE C @ 15 Apr 2010 1535 EDT
Active Medications
Active Medications | Status | Sig | Refills Left | Last Filled
CALCIUM CARBONATE, 500 MG, TAB CHEW, ORAL | Active | takes 4 daily | NR | Not Recorded
HYDROCODONE BIT/ACETAMINOPHEN, 5MG-500MG, TABLET, ORAL | Active | t 1 daily | NR | Not Recorded
IBUPROFEN, 100 MG, TAB CHEW, ORAL | Active | prn for pain | NR | Not Recorded
Screening
Vitals
S/O
Questionnaire AutoCites Refreshed by DOBMEYER,ANNE C @ 15 Apr 2010 1535 EDT
Questionnaires
Population Health Questionnaire-9 Version: 1 Completed On: 15 Apr 2010
1. Little interest or pleasure in doing things: More than half the days (2)
2. Feeling down, depressed, or hopeless: More than half the days (2)
3. Trouble falling or staying asleep, or sleeping too much: More than half the days (2)
4. Feeling tired or having little energy: More than half the days (2)
5. Poor appetite or overeating: Several Days (1)
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down: Several Days (1)
7. Trouble concentrating on things, such as reading the newspaper or watching television: Several Days (1)
8. Moving or speaking so slowly that other people could have noticed OR the opposite (being so fidgety or restless that you have been moving around a lot more than usual): Not at all (0)
9. Thoughts that you would be better off dead or of hurting yourself in some way: Not at all (0)
10. If you checked any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?: Somewhat difficult
11. Total Score on Item 9 = If greater than Zero, alert PCM and consider referral to the Behavioral Health Consultant: 0
12. Total Score: (0-9 = minimal/mild depression, 10-14 = moderate depression, 15-19 = moderately severe depression, 20+ = severe depression). Consider BHC referral if greater than 10 or as clinically indicated.: 11
SO Note Written by DOBMEYER,ANNE C @ 15 Apr 2010 1533 EDT
Chief complaint
The Chief Complaint is: Depression.
Reason for Visit
Visit for: Deployment related = NO. Informed consent provided.
Subjective
Pt was referred by PCM Dr. Doctor for initial Behavioral Health Consultation (BHC) appointment. Reviewed scope of care and limits of confidentiality; informational BHC handout was provided. Pt completed the PHQ-9 (results - see above) indicating moderate sx of depression.

Training

- Rationale for screening
- Overview of each team member's role
- Psychometric overview
- Scoring PHQ-2 and PHQ-9
- Entering results in EMR
- Interpreting results
- Assessment and intervention for suicide risk
- Treatment and referral options and processes

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Quality Assurance

- Identify team member to accomplish quality assurance oversight
  - Percent of visits screened
  - Percent of screenings documented in EMR
  - Percent of "positives" addressed by PCP
  - Percent of "positive" suicide responses with risk assessment/plan documented

Quality Assurance Example

- In first two months, only 82 percent of patients scoring positive on PHQ-2 were given PHQ-9
- PCP/team notified of discrepancies
- Additional training provided to administrative and nursing staff

Responding to Increased Identification of Depression

- If screening, need to have treatment options available
  - Treatment from PCP alone
  - Primary care behavioral health (psychologist or social worker as consultant in primary care)
  - Behavioral health case management for depression (nurse in primary care)
  - Referral to specialty mental health clinic or other resource

Summary

- Screening for depression in primary care:
  - Is feasible!
  - Aids medical team in recognizing and treating depression
  - Can be accomplished with two-item screener
  - Is consistent with VA/DoD CPG and U.S. Preventive Services Task Force recommendations
  - Is enhanced through involvement of behavioral health providers and case managers in primary care

References

Agency for Healthcare Research and Quality (AHRQ) (2002). U.S. Preventive Services Task Force (USPSTF) 2002 Update to the 1996 Guide to Screening for Depression: Recommendations and Rationale; Screening for Depression. *Annals of Internal Medicine, 136,* 760-764.

Coyne, J. C., Schwenk, T.L., & Fechner-Bates, S. (1995). Nondetection of depression by primary care physicians reconsidered. *General Hospital Psychiatry,* 16, 267-276.

Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351,* 13-22.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, k. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry,* 62, 617-627.

Kroenke, K., Spitzer, R.L., & Williams, J.B.W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16,* 606-613.

Kroenke, K., Spitzer, R.L., & Williams, J.B.W. (2003). The PHQ-2: Validity of a brief depression screener. *Medical Care, 41,* 1284-1292.

McQuaid, J. R., Stein, M. B., Laffaye, C., & McCahill, M. E. (1999). Depression in a primary care clinic: the prevalence and impact of an unrecognized disorder. *Journal of Affective Disorders, 55,* 1-10.

Niesenson, L. G., Pepper, C. M., Schwenk, T. L., & Coyne, J. C. (1998). The nature and prevalence of anxiety disorders in primary care. *General Hospital Psychiatry,* 20, 21-28.

Riddle, M. S., Sanders, J. W., Jones, J. J., & Webb, S. C. (2008). Self-reported combat stress indicators among troops deployed to Iraq and Afghanistan: an epidemiological study. *Compr Psychiatry, 49*, 340-345.

Stein, M. B., Kirk, P., Prabhu, V., Grott, M., & Terepa, M. (1995). Mixed anxiety-depression in a primary care clinic. *Journal of Affective Disorders, 34,* 79-84.

VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder (2009).

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Thank You

- Throughout the webinar, you are welcome to submit questions via the Adobe Connect or Defense Connect Online question box located on the screen.
- The question box is monitored during the webinar, and questions will be forwarded to our presenters for response during the question-and-answer session held during the last half hour of the webinar.
- Our presenters will respond to as many questions as time permits.

First Polling Question

Have you used interventions, such as motivational interviewing, behavioral activation and/or problem solving when treating patients for depression?

Please select “YES” or “NO”

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Treating Depression in Military Primary Care Settings

Michael C. Freed, Ph.D.

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Deployment Health Clinical Center
Research Assistant Professor, Department of Psychiatry, Uniformed Services University of the Health Sciences

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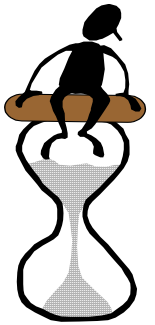
Objectives

- Describe differences between primary and specialty care settings that may impact how depression care is delivered
- Introduce a population-based approach to depression care
- Build a case to improve access to and continuity of care through systems level changes
  - Need more than innovative medication and/or psychotherapy
  - Need more than a behavioral health specialist co-located in a primary care clinic
- Discuss several evidence-based therapeutic techniques that can be used in primary care

Setting Matters: Primary vs. Specialty Mental Health

	Primary Care	Specialty Mental Health
Space	Medical	Office-like
Staff	PCPs, Nurses, Admin Assistants	Psychiatrists, Psychologists, Social Workers, Admins
Visit length	15-20 minutes*	50+ minutes
Reason for service	Anything and everything*	Mental health
Patient expectation	Chief complaint, which may or may not be depression	Mental health related
Operation tempo	Always high	Varied
Skill set	Jack of all trades	Master of a few
Interventions	Medication, brief education, few procedures, refer to specialist	Medication, psychotherapy (multiple modalities), refer to IOP, residential, or inpatient

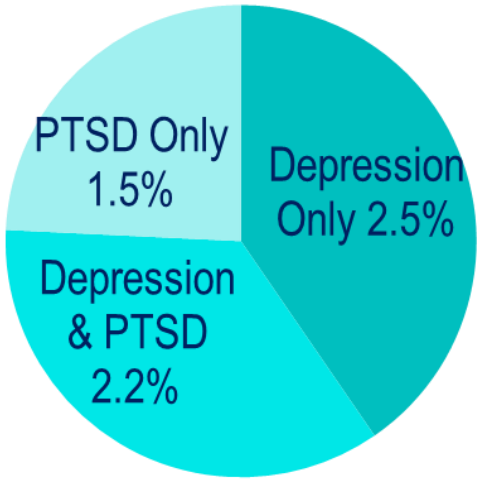
What's in a Primary Care Visit?



- 10-21 minutes is the length of the average primary care visit (Chen, Farwell, & Jha. 2009; Yawn, Goodwin, Zyzanski, & Strange, 2003; Tai-Seale, McGuire, & Zhang, 2007)
- Four to six concerns are discussed per visit (Tai-Seale, McGuire, & Zhang, 2007; Beasley, Hankey, Erickson, et al., 2004)
- Five minutes to discuss the chief complaint on average (Beasley, et al., 2004)
- Mental health problems usurp 85 percent more time to discuss than physical problems (Beasley, et al., 2004)
- Why are we talking about treating depression in primary care if there does not seem to be room to do so?

Why Treat Depression in Primary Care?

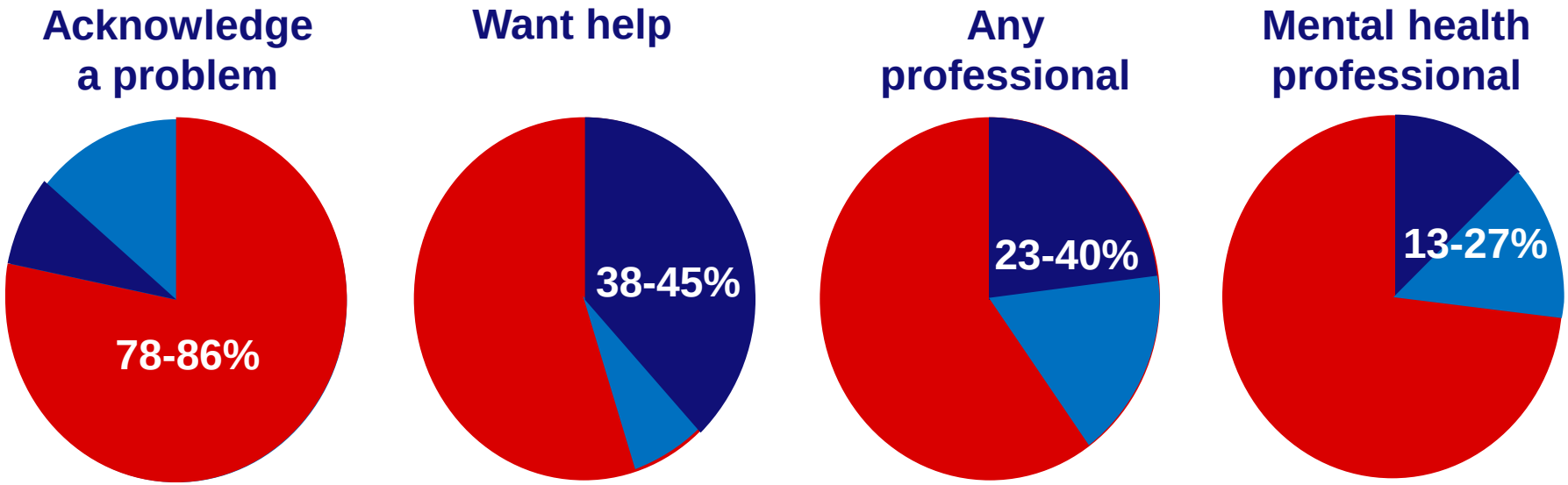
- Primary care is the de facto mental health service system (Regier, et al., 1993)
- Depression is common
  - Active component prevalence of depression is 5 percent (MSMR, 2010)
  - Increases to 14-16 percent in those service members exposed to combat (Wells, et al, 2010; Hoge, et al., 2004)
- Service members go to primary care 3.5 times per year (Engel, 2005)
- And, service members with depression go to primary care (Engel, Freed, et al., AFPHC, 2011)
  - Of ~834k visits to R-Mil between February 2007 and December 2010



Why Treat Depression in Primary Care?

- **A gap exists between needs and services in military and non-military settings** (Tanielian & Jaycox, 2008; Hoge, Auchterlonie, & Milliken, 2006; Kessler, Berglund, Demler, et al., 2003)
  - Among the 20 percent of Soldiers with moderate to severe disorder after OIF deployment (Hoge, et al., 2004)…

Got help (past 12 months)

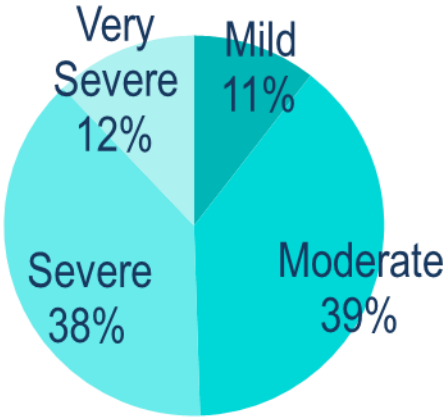


Why Treat Depression in Primary Care?

- Summary
  - Soldiers with depression see their PCPs for medical care
  - There are many soldiers with depression
  - Depression is being treated there anyway
  - Soldiers are not making it to a specialist
- How can we improve the primary care *system* to improve depression care?

A Population-Based Perspective

- Not all depression is the same
  - NCS-R (Kessler, et al., 2003)
  - 16 percent depression of N=9090



- Not all depression treatment is the same
- Maximal efficiency comes from a combination of low- and high-intensity interventions (Engel, Hyams, & Scott, 2006; Engel, Jaffer, Adkins, et al., 2004)
  - Low intensity, low risk, but low resources needed and high reach
  - High intensity, higher risk, higher resources needed and lower reach
- Goal is measurable improvements over a population

A Population-Based Perspective

- **Examples**
  - Referral to specialist in behavioral health for intensive cognitive behavioral therapy and/or more intensive medication
  - Co-located behavioral health provider and/or second-line medication
  - Telephone therapy (Simon, Ludman, Simon, Tutty, et al., 2004) and/or first-line antidepressants
  - Behavioral activation or problem solving therapy in person or over phone with a nurse
  - Self administered or nurse assisted computerized cognitive behavioral therapy, like Beating the Blues (NICE, 2006)
  - Battlemind (Adler, Bliese, McGurk, et al., 2009)
  - Real Men. Real Depression. (NIMH, 2003)
  - We need a *system* that can support *access* to and *continuity* of depression care!

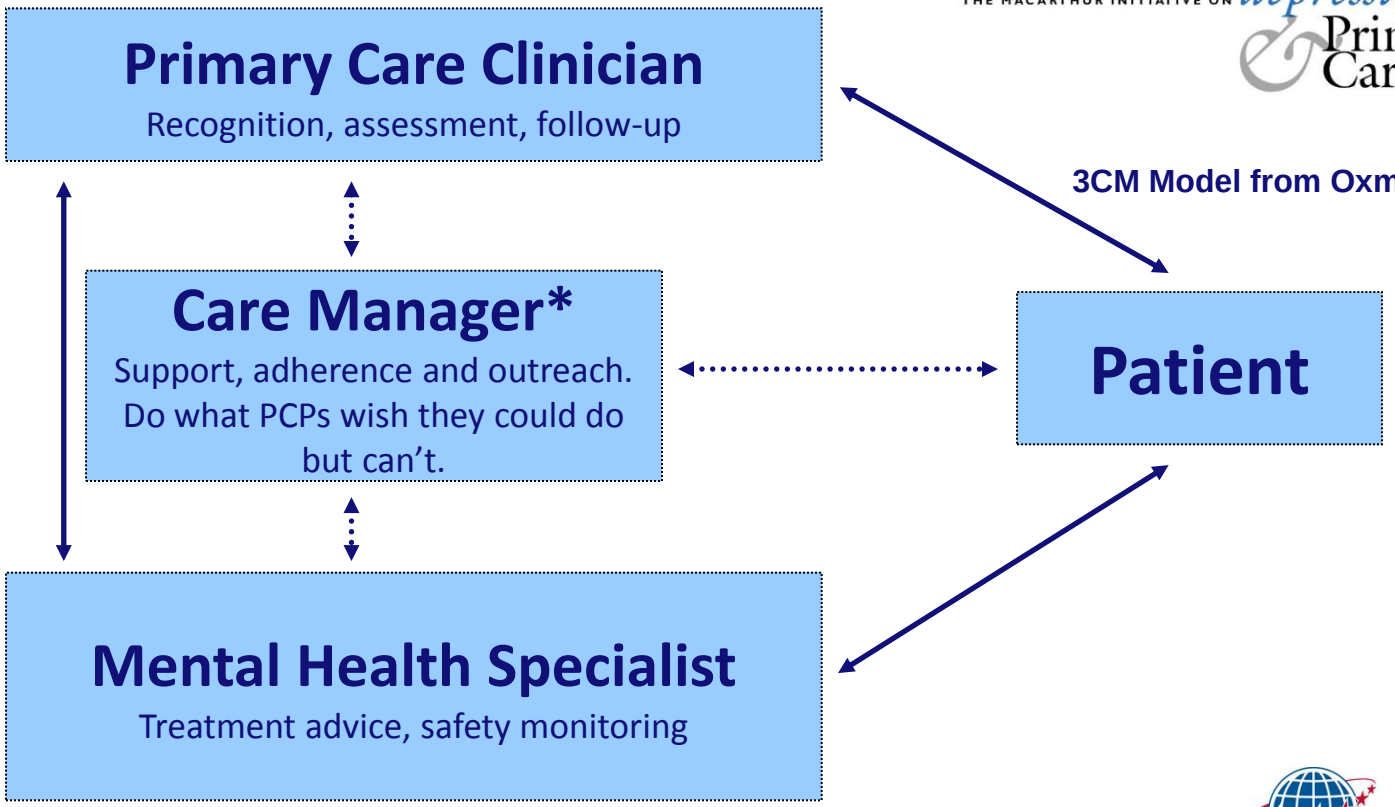
Risk, Resources and Intensity

Population Reach

Collaborative Care

- **Randomized trials offer sound evidence that systems-level interventions improve depression care (Engel et al., 2008; Gilbody et al., 2006; Katon & Guico-Pabia, 2011)**

THE MACARTHUR INITIATIVE ON depression & Primary Care AT DARTMOUTH & DUKE

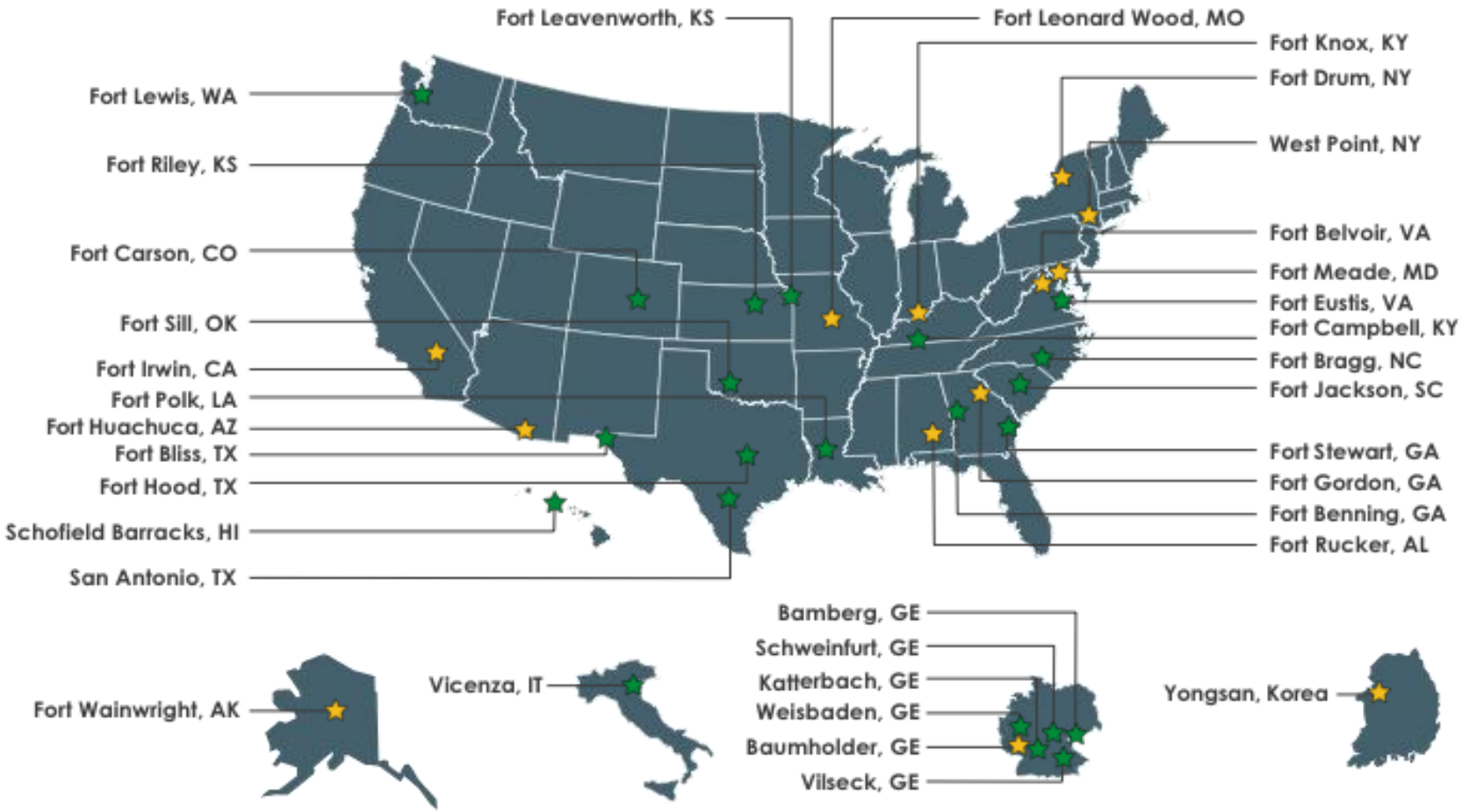


3CM Model from Oxman, et al., 2002

Continuity through Care Management

- 40 percent of patients prematurely discontinue depression medication (Reported in Cantrell, et al., 2006)
- ~25 percent of patients referred to psychotherapy do not attend the first session (reported in Simon, et al., 2011)
- ~25-50 percent of patients prematurely discontinue psychotherapy (Reported in Simon, et al., 2011)
- Compliance (e.g., homework completion) improves outcomes (Burns & Spangler, 2000)
- Care managers should be a "cheap suit" (personal communication, Unützer, 2010)
- Engagement strategies exist
  - Cognitive behavioral (Gorman, et al., 2011) and
  - Motivational interviewing (e.g., van Voorhees, et al., 2009; Zukoff, et al., 2008)

RESPECT-Mil


Fort Leavenworth, KS
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Fort Riley, KS
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Fort Eustis, VA
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Fort Campbell, KY
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Fort Bragg, NC
Fort Polk, LA
Fort Jackson, SC
Fort Huachuca, AZ
Fort Bliss, TX
Fort Stewart, GA
Fort Hood, TX
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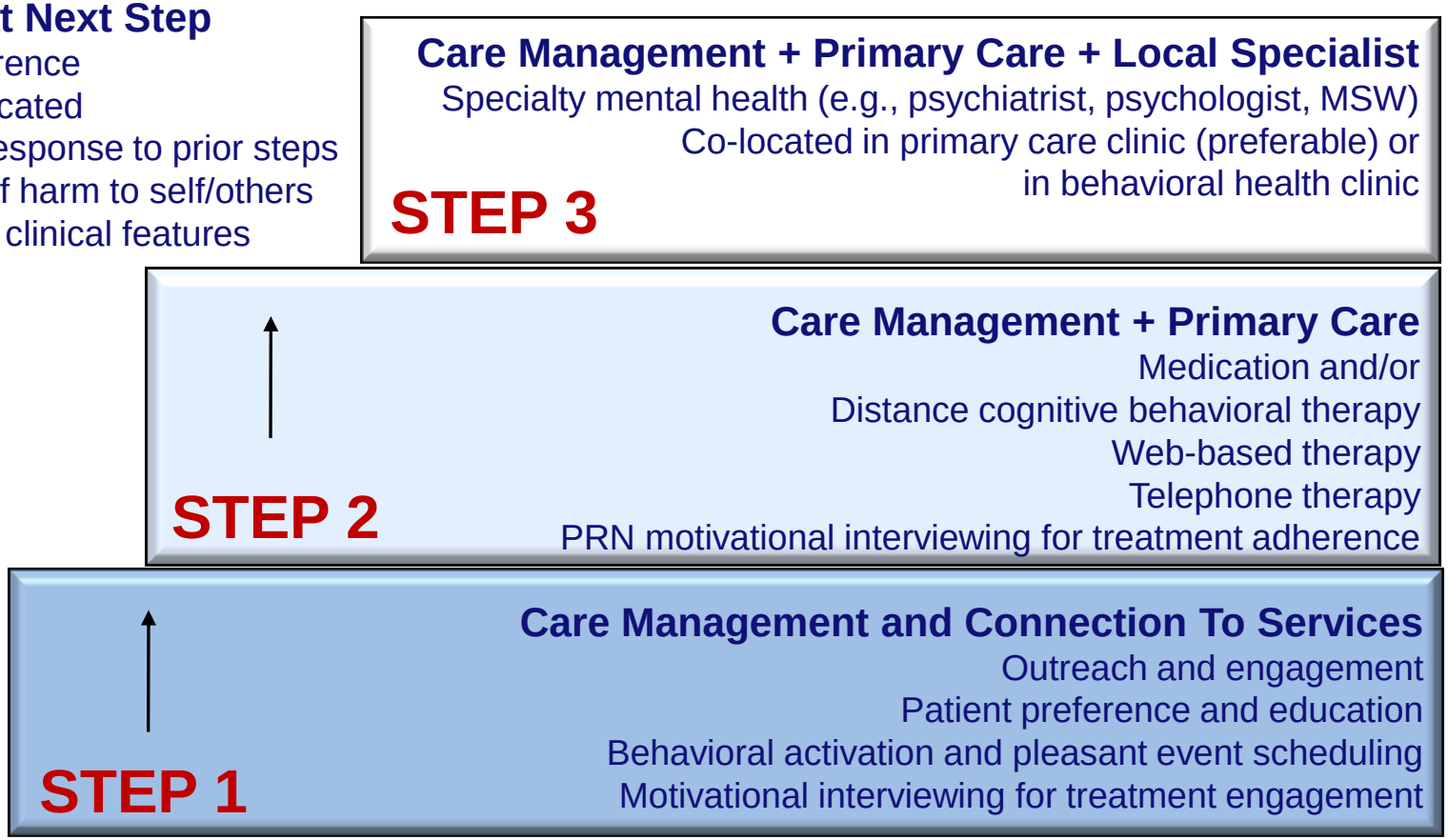
Fort Rucker, AL
Bamberg, GE
Schweinfurt, GE
Katterbach, GE
Weisbaden, GE
Baumholder, GE
Vilseck, GE
Fort Wainwright, AK
Vicenza, IT
Yongsan, Korea
Fully Implemented Sites
Partially Implemented Sites

Building on Collaborative Care

	Usual PC	Co-Location	RESPECT-Mil	STEPS UP*
Screening	Yes	Yes	Yes	Yes*
Case Management	No	No	Local only	Local Central
Stepped Care	No	No	Meds only	Meds Therapy
Measurement-based Care	No	No	Yes	Yes
Routine Specialist Case Review	No	No	Yes	Yes
Embedded Specialist	No	Yes	No	Yes
IT Support	No	No	Yes	Yes

Building on Collaborative Care: STEPS UP

- **Go to/Start at Next Step**
  - Patient preference
  - Clinically indicated
  - Inadequate response to prior steps
  - Clinical risk of harm to self/others
  - Complicating clinical features



(Engel, Freed, Jaycox, Bray, et al., AFPHC, 2011; http://clinicaltrials.gov/ct2/show/NCT01492348)

A Case Example

- John: 24-year-old married male with three kids
  - Chief complaint: recurrent stomach aches and sleep difficulty, resulting in daytime fatigue, feeling run down, irritability with co-workers
  - Mild to moderate depression symptoms from PHQ-9
  - PTSD symptoms due to car accident while deployed
  - Does not like doctors
- Daily Stresses
  - Works 12 hour days but not productive
  - Regular arguments with wife over kids not doing well in school
  - Thinks wife spends too much money
  - On weekends, just wants to be alone and watch TV
  - Problems continuing to get worse
  - Coming to the clinic is a hassle and will not go to behavioral health for fear of someone seeing him
- John wants sleep meds, thinks the stomach aches are "medical," but agreed to talk to a care manager

A Case Example

- Continuity of care will be important with John
- A PCP may not be able to do much at the initial visit beyond first-line meds and referral to a care manager
- Some key questions
  - What does the PCP think about John's presentation?
  - What does John want for his care?
  - What does John understand his options to be?
  - What are John's treatment options?
  - What are John's expectations about treatment – course, intensity, side effects, time commitment, etc.?
- What psychosocial interventions could be used?

Intervention Options

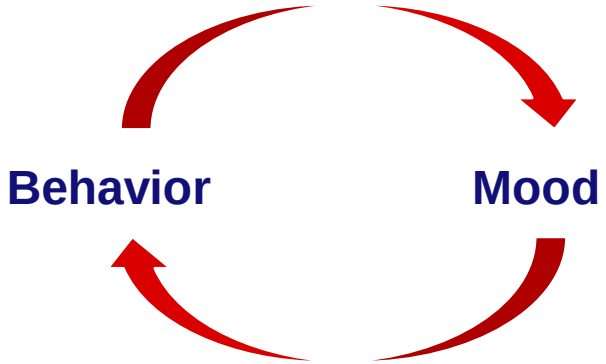
- **Addressing ambivalence and treatment preferences with Motivational Interviewing (MI)** (Arkowitz, Westra, Miller & Rollnick, 2008; Rollnick, Mason, & Butler, 1999)
- **Assess motivation vs. Motivate through lecturing**
  - Express Empathy
  - Develop Discrepancy:
    - ☆ Identify how John's current behavior differs from his/her goals and/or values
    - ☆ By amplifying discrepancy, patients argue for change, rather than the treatment provider
    - ☆ On one hand, on the other hand
  - Roll with Resistance
    - ☆ Avoid power struggles
    - ☆ Join with reasons
  - Support Self-Efficacy

Intervention Options

- **Motivational Interviewing continued: Motivation, Importance, and Confidence rulers**
  - On a scale of 0-10, with 0 meaning not important and 10 meaning extremely important,…
    - ☆ how *Motivated* are you to _____?
    - ☆ how *Important* is it for you to do _____?
    - ☆ how *Confident* are you that _____ will occur?
  - Then, follow up with one of the following questions:
    - ☆ Why did you select X and not (pick a lower number)
    - ☆ What will it take to get you to be a X (pick a higher number)

Intervention Options

- **Behavioral Activation** (Hopko, Lejuez, Ruggiero, et al., 2003; Jacobson, Martell, & Dimidjian, 2001)
  - Smile and you will be happy
  - Do the behavior and the feeling will follow
  - Think enjoyable, social, active, and feasible to do
  - Measure mood before, during, and after
  - Effective in primary care for depression and PTSD (Zatzick, et al., 2011; Jakupcak, et al., 2010)



Intervention Options

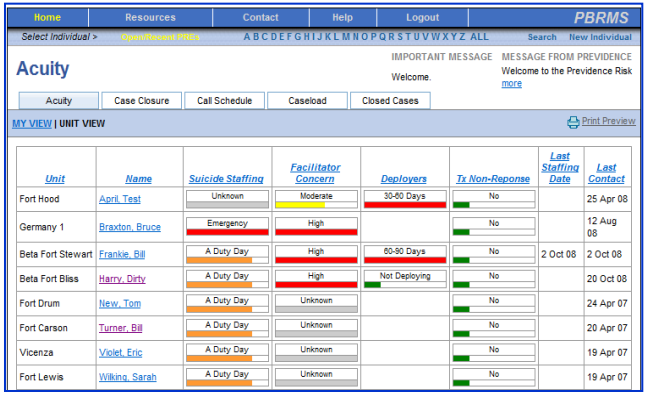
- **Problem-Solving Therapy**
  - Empirically supported for depression in primary care (Mackin & Areán, 2006; Malouff, et al., 2006)
  - One-hour session followed by eight additional session, ~30 minutes each
  - In person or via telephone
  - Action oriented
    1. Clarify and define the problem
    2. Set realistic, achievable goal
    3. Generate multiple solutions
    4. Evaluate and compare solutions
    5. Select a feasible solution
    6. Implement the solution
    7. Evaluate the outcome

Intervention Options

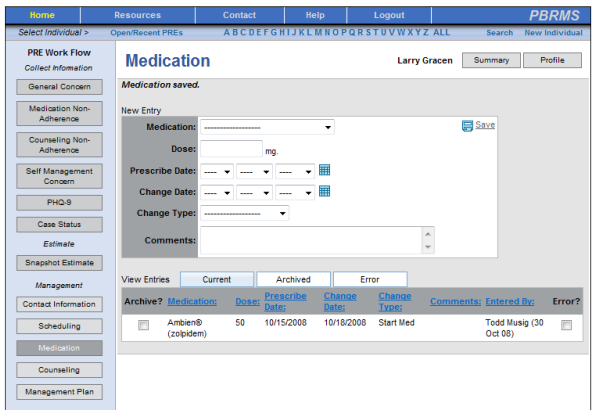
- **Structured treatment packages**
  - **Web-based: Beating the Blues** (NICE, 2006)
    - ☆ Published results supporting its use in primary care settings
    - ☆ Used in the UK's NHSs; new U.S. contract with UPMC; STEPS UP
    - ☆ Eight weekly 50-minute sessions, CBT, homework assignments
    - ☆ Self-management, nurse assisted
    - ☆ Complete any time and anywhere
    - ☆ Provider workload will not delay care

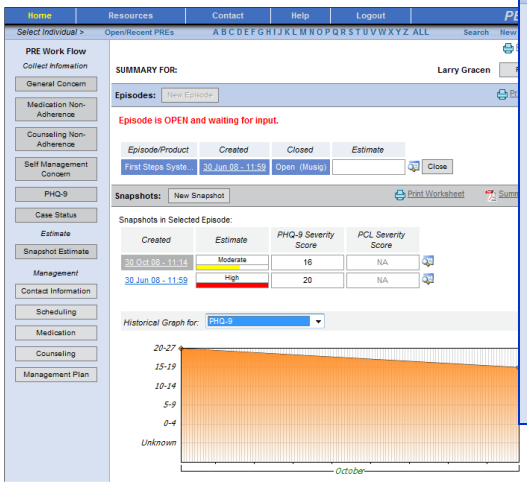
  - **Telephone therapy** (Simon, Ludman, Tutty, et al., 2004)
    - ☆ One therapist can cover multiple clinics
    - ☆ No stigma from being seen walking into behavioral health
    - ☆ Contains core CBT elements for depression treatment
    - ☆ But still not one size fits all because patient talks with a person

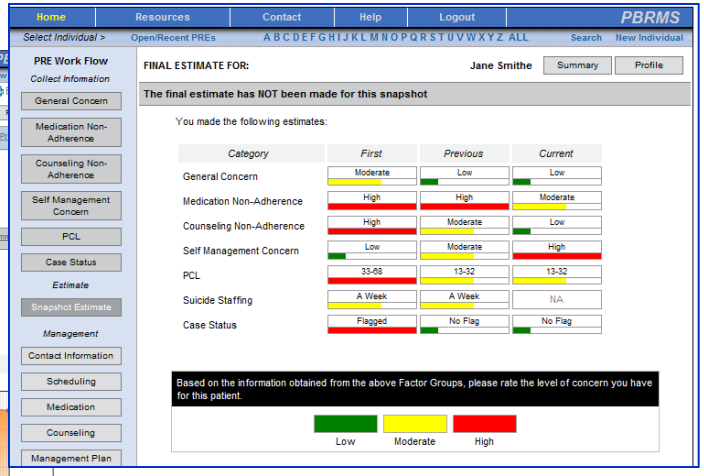
Information Technology Can Help



- **FIRST-STEPS**
  - Defense Department approved software designed to manage symptoms, treatment response and risk
  - Currently used in RESPECT-Mil sites and facilitates the monitoring of patient symptoms and supervision sessions
  - Provides clinicians with the ability to document and monitor suicide risk, providing a set of standardized questions







Uniformed Services University of the Health Sciences

DEFENSE CENTERS OF EXCELLENCE For Psychological Health & Traumatic Brain Injury

DHCC DEPLOYMENT HEALTH CLINICAL CENTER

Summary

- Important differences exist between primary- and specialty-care settings
- Treating depression in primary care is more than just co-locating a specialist in the primary care clinic: *system* changes are needed
- Patients may not be initially presenting with or seeking help for depression
- Care coordination is important for improving *access* and *continuity*
- Basic collaborative care model helps PCPs manage patient pharmacologically though care management and psychiatric consultation
- Psychosocial interventions should be brief, targeted and flexible to meet needs and preferences of the patient

Thank You

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- Our presenters will respond to as many questions as time permits.

Second Polling Question

Are you familiar with the VA/DoD Clinical Practice Guideline for Major Depressive Disorder in Adults: Primary Care?

Please select “YES” or “NO”

DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Major Depressive Disorder Clinical Support Tools

Lt. Col. Philip A. Holcombe, Ph.D.

Psychological Health Clinical Standards of Care
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
National Center for Telehealth & Technology

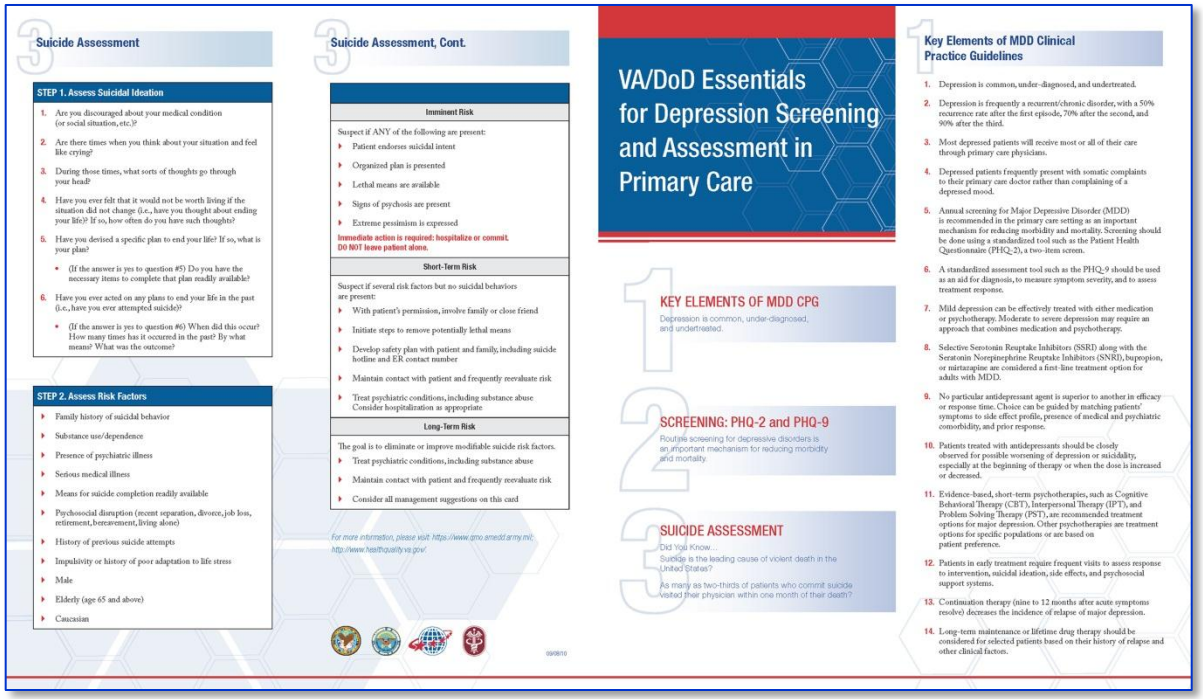
Required Disclaimer

I have no relevant financial relationships and do not intend to discuss the off-label/investigative (unapproved) use of commercial products or devices.

VA/DoD Clinical Practice Guideline for Major Depressive Disorder in Adults: Primary Care

1. Use of Patient Health Questionnaire (PHQ)-2
2. Conditions recommended for emergency referral for dangerousness evaluation
3. Clinical assessment guidelines
4. Severity classification using PHQ-9
5. Collaborative treatment planning
6. Monitor treatment response using PHQ-9 and consideration of specialty referral

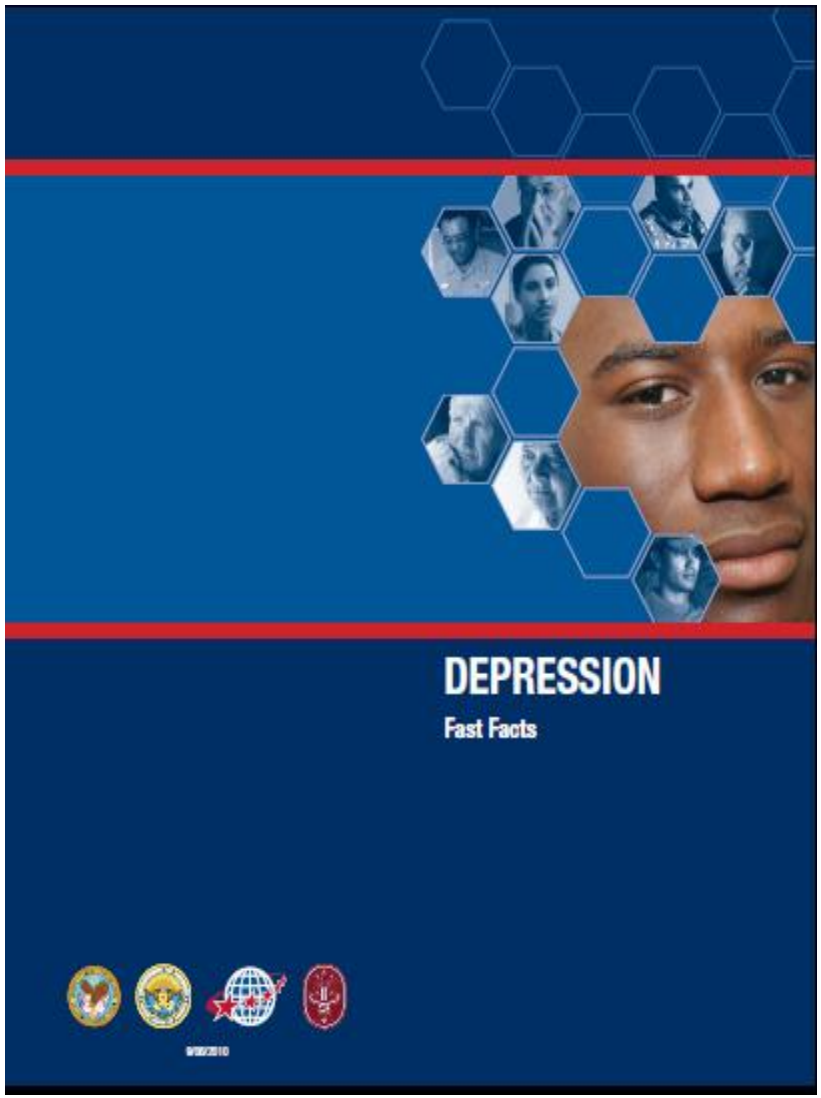
Depression Screening



Three-Step Screening Process:

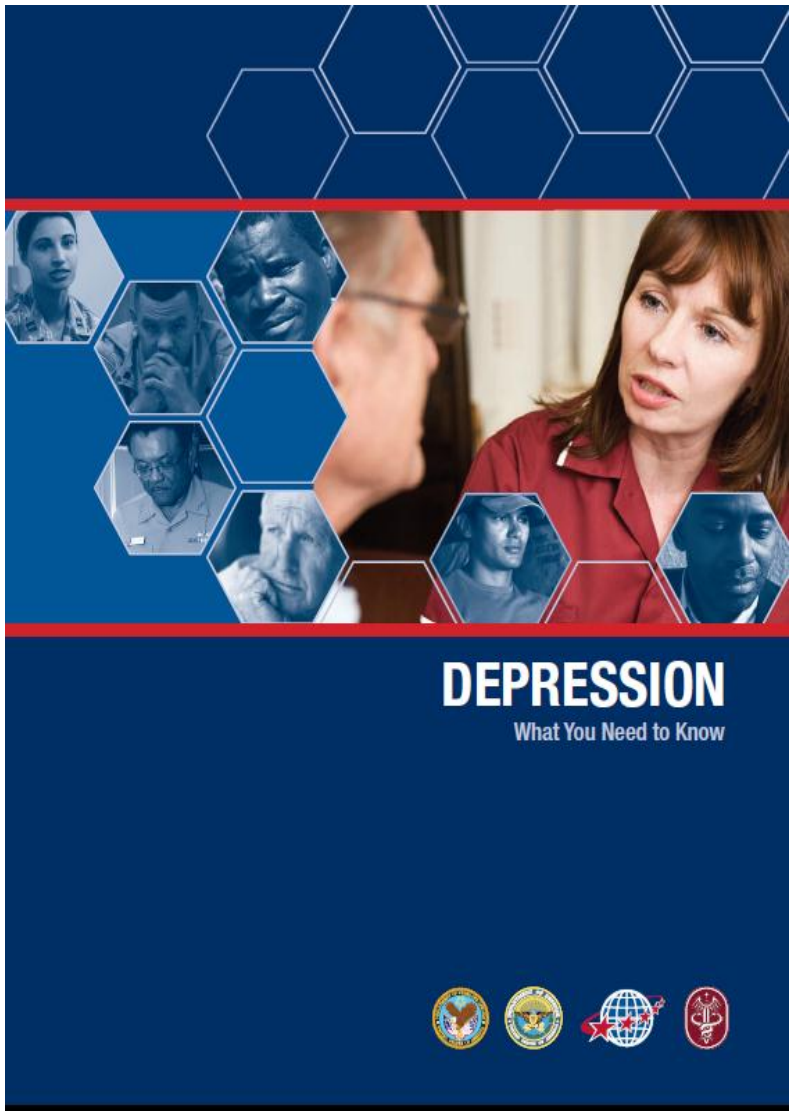
- 14 key elements related to the guideline
- PHQ-2 and -9 for periodic screening
- Suicide risk assessment questions and some key response recommendations

Depression Fast Facts



- PHQ-2
- Facts designed to destigmatize experiencing depressive symptoms
- List of symptoms
- Tips for self-care, treatment expectations and active participation in care

Patient Workbook



- Reflects patient pamphlet
- Self-management
- What to expect in treatment
- Tips for self-care, sharing diagnosis with others, building a support network and sleep hygiene

Resources

- To download or order hard copies of the tools, screening pocket and exam room cards, and full-length clinical practice guideline, please visit MEDCOM's website: **https://www.qmo.amedd.army.mil/QMOCPGShopCart/products.asp?cat=6**

- Please send feedback to: **CST_feedback@tma.osd.mil**

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Question-and-Answer Session

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- Did you pre-register prior to **May 21, 2012**?
  - If yes, please visit **conf.swankhealth.com/dcoe** to complete the online CEU/CME evaluation and download your continuing education certificate.

- Did you pre-register between **May 22, 2012**, and now?
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- The Swank Health website will be open until **June 25, 2012**.
  - If you did not pre-register, you will not be able to receive CE credit for this event.

Save the Date

DCoE Monthly Webinar:

Intimate Partner Violence: What Health Care Providers Need to Know

June 28, 2012
1-2:30 p.m. (EDT)

JUNE						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

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