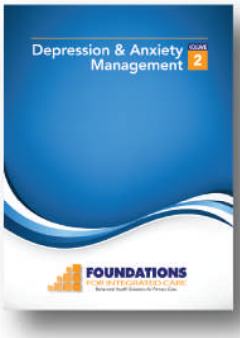
Clinician Resources

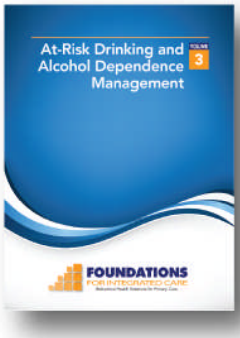
VOLUME 5

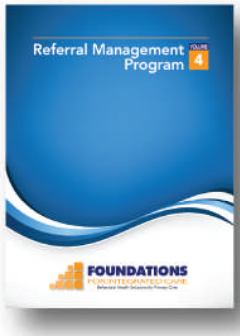
FOUNDATIONS
FOR INTEGRATED CARE
Behavioral Health Solutions for Primary Care.

Foundations for Integrated Care

LEARNING MAP







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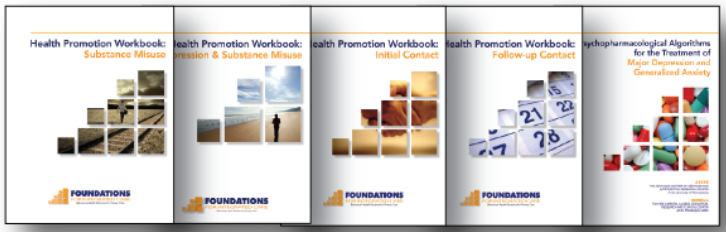

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How to use this Resource Guide

The material in this appendix is meant to complement the training guides. These materials are for your benefit to use as quick references to guide your visit, or to supplement your knowledge. These are not written for the patient and in general should not be given to the patient. The materials in this appendix are to be considered a starting point for your program. You will undoubtedly develop your own library of resource material, as well as, modify the resources in this appendix. All of the material in this manual it is intended for you to copy and use with your clinical program. However, please do not use this resource material for commercial use.

Tips for Use
we recommended that this volume be used primarily by referring to the table of contents for applicable resources. Is not meant to be read cover to cover. Find the resource in the table of contents, then flip to the page number. Within each section, the documents are organized alphabetically.

SECTION 1

Clinician Administered

Blessed Orientation Memory Concentration (BOMC)

The Blessed test is routinely administered to patients >=55 years old but may be used whenever a screen for cognitive disability if clinically indicated, such as known history of head trauma.

"Now I would like to ask you some questions to check your memory and concentration. Some of the questions may be easy and some of them may be hard."

1. What year is it now?
   Record number of errors: ☐ 0 ☐ 1 (0 = Incorrect 1 = Correct)

2. What month is it now?
   Record number of errors: ☐ 0 ☐ 1 (0 = Incorrect 1 = Correct)

3. *"Please repeat this phrase after me: "John Brown, 42 Market St., Chicago."*

4. About what time is it? (Correct within one hour)
   Record number of errors: ☐ 0 ☐ 1 (0 = Incorrect 1 = Correct)

5. Now I would like you to count backwards from 20 to 1.
   Record number of errors: ☐ 0 ☐ 1 (0 = Incorrect 1 = Correct)

6. Now I would like you just say the months of the year in reverse order. ?
   Record number of errors: ☐ 0 ☐ 1 (0 = Incorrect 1 = Correct)

7. Now please repeat the memory phrase.
   Record number of errors: ☐ 0 ☐ 1 (0 = Incorrect 1 = Correct)

It is recommended that patient answers be recorded as she/he responds for potential later reference in calculating total weighted score.

Blessed OMC (Orientation-Memory-Concentration) Scoring Instructions:

Scoring individual items:

The score for 6 items are multiplied to yield a "weighted" score. The higher the total weighted score, the more likely the patient has cognitive disability. Weight scores totaling greater than 10 are generally accepted as an indication of the presence of clinically meaningful cognitive impairment.

For items 1, 2 and 3, score "0" for correct response and score "1" for an incorrect response.

4 items 4 and 5, score "0", for correct with no errors, score "1" for correct with noted errors that were self corrected, and score "2" for the presence of any uncorrected errors.

Scoring the Memory Phrase

If notes you is necessary and the patient recalls both the name and the address, score "0". If the patient cannot spontaneously recall the name and address, cue With "John Brown" one time only. If this queue is necessary, the patient automatically has at least 2 errors.

Blessed Memory Test continued

Score one point for each subsequent "unit" the patient cannot recall.

Determining Weighted Total Score:

Insert the patient score for each item in the table below, determine the weighted score for each item I completing the required multiplication for each item, then total score.

Item	Max error	Patient Score	Multiplier	Weighted Score
Year	1		X4	=
Month	1		X3	=
Time	1		X4	=
Count back 20 to 1	2		X 2	=
Months in reverse	2		X 2	=
Memory phrase (1) John (2) Brown (3) 42 (4) Market (5) Chicago	5		X 2	=
				Total =

Source: Katzman R., et al. validation of a short orientation-memory-concentration test of cognitive impairment.Am T Psychiatry 1983:140:734-9.

Clinical Institutes Withdrawal Assessments for Alcohol (CIWA)

1. Pulse or heart rate, taken for one minute: _____ (beats per minute)
2. Blood Pressure: _____/ _____
SBP DBP

Circle one rating score for each of the following responses.

3. NAUSEA AND VOMITING
Ask "Do you feel sick to your stomach? Have you vomited?" Observation:

0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

4. ANXIETY
Ask "Do you feel nervous?" Observation:

0 no anxiety, at ease
1 mildly anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

5. **TREMOR**
Arms extended and fingers spread apart. Observation:

0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

6. AGITATION

0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

7. PAROXYSMAL SWEATS

0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

Clinical Institutes Withdrawal Assessments for Alcohol (CIWA) continued

8. TACTILE DISTURBANCES
Ask "Have you any itching, pins and needles sensations, any burning, any numbness or do you feel bugs crawling on or under your skin?" Observation:

0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

9. AUDITORY DISTURBANCES
Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation:

0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

10. VISUAL DISTURBANCES
Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation:

0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 ontinuous hallucinations

11. HEADACHE, FULLNESS IN HEAD
Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

12. ORIENTATION AND CLOUDING OF SENSORIUM
Ask "What day is this? Where are you? Who am I?"

0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place and/or person

13. Total CIWA Score _____ (Maximum Possible Score 67)

Paykel Assessment

SUICIDAL IDEATION

1) Has there been a time in the last year when you thought life was not worth living?

- ☐ Yes
- ☐ No

2) Has there been a time in the last year that you wished you were dead, for instance you would go to sleep and not wakeup?

- ☐ Yes
- ☐ No

3) Has there been a time in the last year that you thought of taking your own life, even if you would not really do it?

- ☐ Yes
- ☐ No

4) Has there been a time in the last year when you reached a point where you seriously considered taking your own life or perhaps made plans about how you would go about doing it?

- ☐ Yes
- ☐ No

5) In the last year, have you made an attempt on your life?

- ☐ Yes
- ☐ No

Suicide Risk Assessment

1. Suicide ideation, threats, or attempts within 30 days
   - ☐ Patient has no suicidal ideation
   - ☐ Patient has suicidal ideation or threat of self-harm
   - ☐ Patient has made a suicide attempt or gesture in the last 30 days.

2. Risk Factors for Suicide Attempts
   - ☐ Prior suicide attempt (lifetime)
   - ☐ Hopelessness
   - ☐ Current severe psychiatric disorder including substance abuse
   - ☐ Command hallucinations to hurt self
   - ☐ Highly impulsive behavior
   - ☐ Agitation or severe anxiety
   - ☐ Perceived burden on family or others
   - ☐ Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
   - ☐ Homicidal ideation
   - ☐ Aggressive behavior towards others
   - ☐ Method for suicide available (gun, pills, etc.)
   - ☐ Refuses or feels unable to agree to safety plan

3. Protective Factors
   - ☐ Identifies reasons for living
   - ☐ Responsibility to family or others; living with family
   - ☐ Supportive social network or family
   - ☐ Fear of death or dying due to pain and suffering
   - ☐ Belief that suicide is immoral, high spirituality
   - ☐ Engaged in work or school
   - ☐ Motivated to exaggerate suicide risk

4. Estimated Risk Factors
   - ☐ High, with recent attempt (Suicide Prevention Coordinator notified)
   - ☐ High (Suicide Prevention Coordinator notified)
   - ☐ Moderate
   - ☐ Low

5. Treatment planning
   - ☐ Low risk with no active suicidal ideation – patient give phone number for Hotline 1-800- 273-TALK. No additional suicide prevention measures warranted at this time.
   - ☐ Immediate life safety plan implemented (patient admitted to hospital)
   - ☐ Outpatient life safety plan revised
   - ☐ Follow-up outpatient appointment (date and provider)
   - ☐ Medication changes
   - ☐ Contact with caretakers
   - ☐ Address risk factors (especially access to means)
   - ☐ Strengthen protective factors
   - ☐ Develop an outpatient safety plan (safety plan note template)
   - ☐ Add cognitive behavioral therapy

SECTION 2

Clinical Materials for Behavioral Health Providers

Advance Preparations for Alcohol Care Management (Initial Session)	
Patient ID # _____ Session # _____ BHP Name _____ Date _____	
√	**Gather and review information that was already collected from the patient and will be needed for the Clinician Report Form for the Initial Session:**
	Medical Information: Double-check lab report, and record any other drinking-related medical symptoms as noted on physical examination or lab reports.
	Alcohol Use: Record the number of drinking days per week and average number of drinks per drinking day from the Timeline Follow back method or a similar drinking collection method.
	Consequences of Drinking: Record one to three negative consequences acknowledged by the patient. Select items from the DrInC (MMC #1a) or a similar drinking consequence collection method with the highest score or impact to discuss as examples of drinking-related problems.
	Diagnostic Information: Review symptoms of alcohol dependence from diagnostic evaluation.
√	**Optional Items for the Initial Session:**
	Vital Signs
	BAC
	Prior and Concomitant Medications Form
	Adverse Events Log
	Serious Adverse Event Form
	Medication Adherence Plan
	Medical Session Attendance Calendar
	Self-Help Group Information
	Other Treatment Services Utilization

Alcohol Care Management Checklist (Initial Session)

Patient ID # _____ **Session #** _____

BHP Name _____ **Date** _____

Session start time: _____ ☐ **AM** ☐ **PM** **COMPLETED?**

1) Structuring statement: Describe your role, # & length of sessions ☐ Yes ☐ No

2) Present to patient his/her medical status

Vitals--BAC ____ T _____ P ____B/P ____/_____ Wt ____ lbs ☐ Yes ☐ No

Ask about current medications & pre-existing somatic complaints ☐ Yes ☐ No

Review with patient:
Lab results--AST_____ ALT _____ GGT _____ MCV _____ ☐ Yes ☐ No

Other abnormal results: _____

Other medical problems from alcohol use: _____

3) Briefly explain to patient how alcohol affects the liver & other organs ☐ Yes ☐ No

4) Present to patient his/her drinking pattern and hazardous alcohol use ☐ Yes ☐ No

5) Present to patient each DSM alcohol dependence symptom that he/she has ☐ Yes ☐ No

6) Ask patient for two (2) goals for treatment:

1: _____ ☐ Yes ☐ No

2: _____ ☐ Yes ☐ No

7) Summarize patient's medical problems, drinking level dependence ☐ Yes ☐ No

8) Recommend abstinence to patient; discuss its possibility ☐ Yes ☐ No

9) Present patient reasons for taking medication, describe study meds/dosing schedule, possible side effects, importance of adherence, returning pills, emergency procedures. ☐ Yes ☐ No

10) Also, remember to distinguish med from disulfiram & detox meds ☐ Yes ☐ No

11) Recommend support groups as an aid to change ☐ Yes ☐ No

12) Schedule/verify next session ☐ Yes ☐ No

End start time: _____ ☐ **AM** ☐ **PM**

Alcohol Care Management Checklist (Follow-up)

Patient ID # _____ **Session #** _____

BHP Name _____ **Date** _____

Session start time: _____ ☐ **AM** ☐ **PM** **COMPLETED?**

1) Opening statement: *"How have you been?"* ☐ Yes ☐ No

2) Present to patient his/her medical status

Vitals--BAC ____ T _____ P ____B/P ____/_____ Wt ____ lbs ☐ Yes ☐ No

Ask about current medications & pre-existing somatic complaints ☐ Yes ☐ No

Review with patient:
Lab results--AST_____ ALT _____ GGT _____ MCV _____ ☐ Yes ☐ No

Other abnormal results: _____

Other medical problems from alcohol use: _____

3) Ask patient about drinking to determine patient's drinking status ☐ Yes ☐ No

4) Ask patient if the prescribed medication was taken as directed ☐ Yes ☐ No

5) Determine patient's status (answers to 3 & 4 above) (check only one)

☐ Abstinent/Adherent ☐ Non-Abstinent/Adherent

☐ Abstinent/Non-Adherent ☐ Non-Abstinent/Non-Adherent

6) Provide direct advice based on patient's status (1 of 4 dialogues) ☐ Yes ☐ No

7) Patient change since in treatment? (Check only one)
☐ Improved ☐ No/ Minimal Change ☐ Worse

8) Ask patient about/ encourage support group attendance ☐ Yes ☐ No

9) Remind patient how medication works & promote continued use ☐ Yes ☐ No

10) Encourage/praise patient's efforts ☐ Yes ☐ No

11) Schedule/verify next session ☐ Yes ☐ No

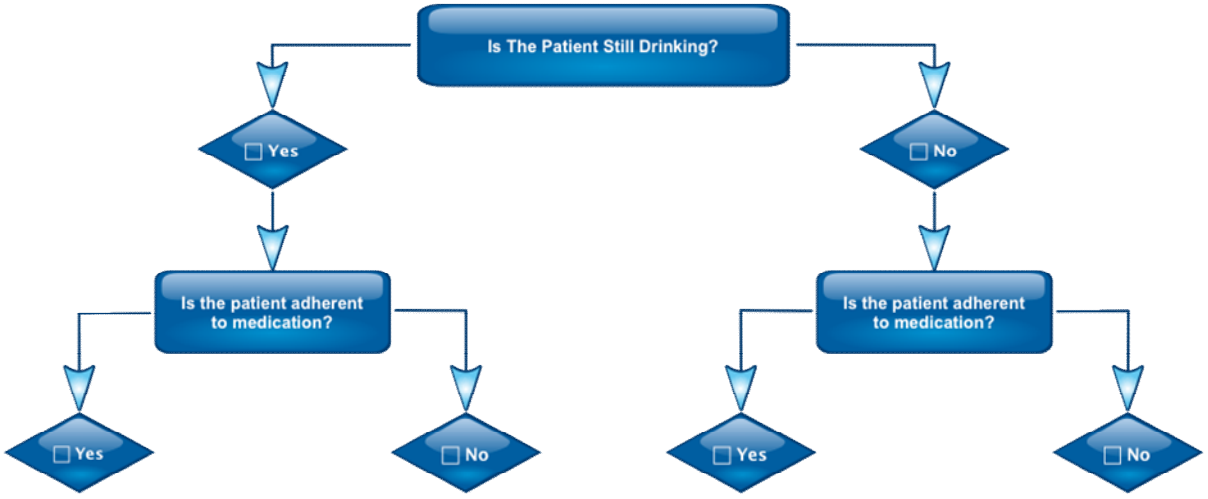
End start time: _____ ☐ **AM** ☐ **PM**

Alcohol Care Management Follow-up Session Dialogue Flowchart

Patient ID # _____ **Session #** _____

BHP Name _____ **Date** _____

Put checks in the boxes for dialogue that occurred for the session



- ☐ Congratulate patient for not drinking
- ☐ Review benefits of abstinence
- ☐ Review benefits of pharmacotherapy
- ☐ Ask why medication is not taken regularly
- ☐ Explore remedies to correct non-adherence
- ☐ Set the next appointment

- ☐ Reinforce patient's ability to follow advice and stick to the plan
- ☐ Ask what the patient did to achieve this outcome
- ☐ Encourage patient to stick with the plan- "keep up the good work!"
- ☐ Review benefits of abstinence
- ☐ Set the next appointment

- ☐ Review initial reasons for seeking treatment
- ☐ Review benefits of abstinence
- ☐ Review benefits of medication
- ☐ Review reasons for med non-adherence
- ☐ Create new adherence plan
- ☐ Ask patient to "give treatment a chance"
- ☐ Set the next appointment

- ☐ Praise any small steps toward abstinence
- ☐ Review benefits of abstinence
- ☐ Review benefits of mutual support group meetings
- ☐ Remind patient that medication takes time to work
- ☐ Set the next appointment

Other recommendations (e.g. side effects management, new adherence plan):

_____

Follow-up: ☐ Continue the current treatment plan
☐ Change the treatment plan as follows: _____

_____

☐ Refer for medical evaluation
Next appointment date: _____

Medication Adherence Plan

Patient ID # _____ **Session #** _____

BHP Name _____ **Date** _____

(I) Examine Patient's History of Medication/Vitamin-Taking Practices

A. Determine Patient's Experience with Pill-Taking

For each item below, check a "Yes" or "No." If "Yes", indicate in the next column if patient was successful at taking the pills under the conditions specified. If the patient has not had the opportunity to experience such an event, check (N/A).

	Patient Response	**Was Patient Successful?**
	☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A
Have you ever been asked to take, or have you ever taken any pills on a daily basis?	☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A
Have you ever been asked to take or have you ever taken pills at the same time each day for 3 months or more?	☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A
Have you ever been asked to take or have you ever taken pills from a blister card?	☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A
Do you typically carry pills on or with you?	☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A
Have you ever been asked to take prescribed medications until all pills were gone?	☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A

NOTES:

_____

_____

_____

Medication Adherence Plan continued

B. Examine Patient's History of Medication/Vitamin-Taking Practices

Optional: Review common reasons for pill non-adherence.

To be used when appropriate per patient. However, suggested use is with all patients at the Initial Session.

Ask patient: *"Might any of the following common situations be problems for you when taking medication?"*
(Check all that apply)

- ☐ Forgets to take or loses medications
- ☐ Worries about side effects
- ☐ Believes he/she is taking placebo
- ☐ Has misinformation about medications (e.g., expects instant changes in drinking)
- ☐ Has never liked taking pills–even aspirin
- ☐ Desires to drink or "get high"
- ☐ Tires of taking pills every day
- ☐ Disagrees about having an alcohol disorder
- ☐ Feels like he/she no longer needs medication

Tell patient: *"If any of these situations occur, please talk to me about it."*

NOTES:

_____

C. Discuss Successful Pill-Taking Strategies
List any pill-taking strategies that the patient uses/has used and were successful. If the patient has no prior pill-taking experience, have him/her think of strategies for remembering to take pills and list them here:

_____

D. Plan: Based on patient responses to above questions, check one below that best applies to this patient:

- ☐ Experienced/successful with daily pill taking. May not need a new plan.
- ☐ Experienced but has NOT been successful with daily pill taking. Requires a comprehensive plan with continual re-evaluation.
- ☐ No experience with daily pill taking. Requires a basic plan.

(II) Personalized Medication Adherence Plan

Record date: _____/_____/20_____
Month Day Year

Note: This plan can be revised as needed.

Resources for Addiction Care

National Organizations:

The National Institute on Alcohol Abuse and Alcoholism (NIAAA)
NIAAA
6000 Executive Boulevard
Bethesda, MD 20892-7003
(301) 443-3860.
http://www.niaaa.nih.gov

Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Rockwall II
Rockville, Maryland 20857
301-443-0365
http://www.samhsa.gov/

Center for Substance Abuse Prevention
5600 Fishers Lane, Rockwall II
Rockville, Maryland 20857
301-443-0365
http://www.samhsa.gov/csap/index.htm

Center for Substance Abuse Treatment
5600 Fishers Lane, Rockwall II
Rockville, Maryland 20857
301-443-0365
http://www.samhsa.gov/csat/csat.htm

Alcoholics Anonymous (AA)
Check the phone book for a local chapter or write the national office at:
475 Riverside Drive, 11th Floor
New York, NY 10115; or call
(212) 870-3400.

The National Council on Alcoholism and Drug Dependence, Inc., can refer you to treatment services in your area.
National Headquarters
NCADD
12 West 21st Street
8th Floor
New York, NY 10010
(800) NCA-CALL (800-622-2255).

The National Institute on Aging offers a variety of resources on health and aging

NIA Information Center
P.O. Box 8057
Gaithersburg, MD 20898-8057
(800) 222-2225, TTY (800) 222-4225.
http://www.nia.nih.gov

Published Material

Substance Abuse Among Older Adults, Treatment Improvement Protocol (TIP) Series 26

Frederic C. Blow, Ph.D., Consensus Panel Chair
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
DHHS Publication No. (SMA) 98-3179
Printed 1998
Available on the web at http://www.samhsa.gov/csat/csat.htm

Brief Interventions And Brief Therapies for Substance Abuse, Treatment Improvement Protocol (TIP) Series 34

Kristen L Barry, Ph.D., Consensus Panel Chair
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
DHHS Publication No. (SMA) 99-3353
Printed 1999
Available on the web at http://www.samhsa.gov/csat/csat.htm

Other useful websites

Motivational Interviewing website:
http://www.motivationalinterview.org/

Brief Motivation Interventions for Substance Using Patients
http://vaww.chce.research.va.gov/apps/bmiforsuv/default.html

Stages of Change: Key Features

"It's not that some people have willpower and some don't. It's that some people are ready to change and others are not."

~James Gordon, M.D.

Change is not a concrete process, but rather, a fluid process. Individuals tend to move through different "stages of change" in the management of medical problems. These stages include: 1) pre-contemplation, 2) contemplation, 3) preparation, 4) action, and 5) maintenance.

Pre-contemplation

- People in this stage have no intention to take action to change a behavior in the foreseeable future.
- Often individuals in this stage are not aware of the importance of a change or may deny the negative impact of their current behavior.
- Few benefits to change can be seen by the person.

Contemplation

- People in this stage intend to take action to change in the foreseeable future, but not right away.
- Typically, they desire to change sometime in the next 6 months.
- Individuals in this stage see the benefits of change, but they do not outweigh the difficulties of change.
- Some individuals will get "stuck" in this stage–always knowing they should change, seeing the benefits, but not moving towards action.

Preparation

- People in this stage are intending to take action within the next 30 days.
- They are ready to change, see the benefits of change, and are actively making a plan to change.
- For example, such individuals trying to change their exercise behavior might be researching different gyms to join, buying walking shoes, or getting an exercise partner.

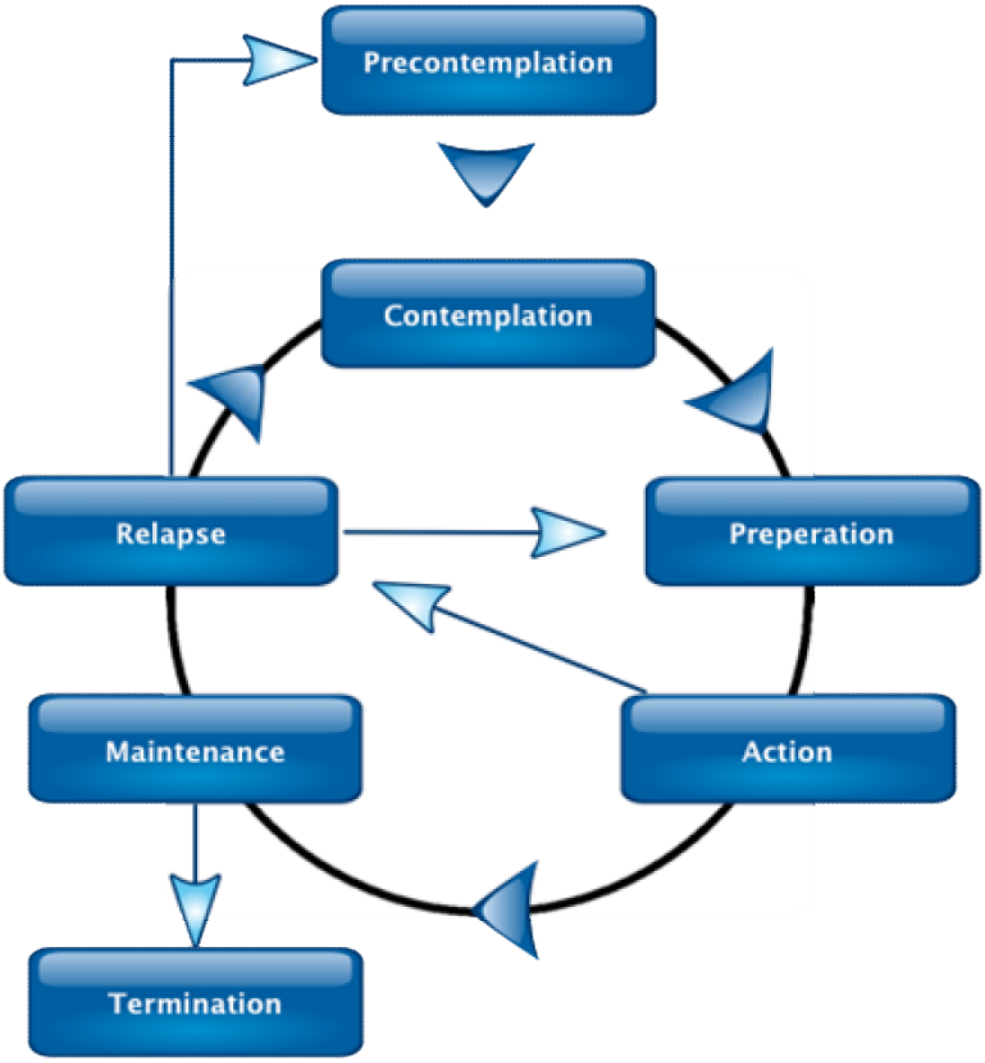
Action

- Individuals in this stage have successfully made a change in their behavior within the past 6 months.
- To truly be in this stage, a person must have achieved the behavior at a level sufficient to reduce the targeted health risk.

Stages of Change: Key Features continued

Maintenance

- Individuals in this stage have successfully continued a desired behavior for at least 6 months.
- People in this stage are usually confident they can maintain their new behavior and likely experience few temptations to return to previous behaviors.



The Center for Integrated Healthcare gratefully acknowledges the work of Lisa Kearney, PhD in preparation of this summary.

Suggested Laboratory Tests for Alcohol Addiction

AST and ALT. AST (aspartate animotransferase, previously called SGOT) and ALT (alanine transferase; previously called SGPT) are enzymes that reflect the overall health of the liver. The liver is important in metabolism of food and energy, and also filters and neutralizes poisons and impurities from the blood. (The analogy to an oil filer is helpful for some.) When the liver is damaged, as happens from heavy drinking, it becomes less efficient in these tasks, and begins to leak enzymes into the bloodstream. Elevated levels of these enzymes are general indicators of compromised liver function.

GGT. Serum gamma glutamyl transpeptidase (GGT or GGTP) is an enzyme found in liver, blood, and brain, which is more specifically sensitive to alcohol's effects. If drinking continues, elevations of this enzyme predict later serious medical problems related to drinking, including injuries, illnesses, hospitalizations, and deaths. This enzyme is often elevated first, with AST and ALT rising into the abnormal range as heavy drinking continues. Elevations on serum test scores can occur for reasons other than heavy drinking. GGT, for example, can be elevated by cancer or hormonal changes. In this population, however, the most likely cause of an elevation is heavy drinking. These test values tend to return toward normal if the person stops drinking. Reductions in GGT (by changed drinking) have been shown to be associated with substantially reduced risk of serious health problems. GGT is also sensitive to *recent* drinking, and an elevation may reflect a recent heavy drinking episode.

MCV. This is not a liver function measure, but rather is *mean corpuscular volume*, the average size of red blood cells. Heavy drinking causes blood cells not to have enough hemoglobin which is necessary to carry oxygen around the body and brain. Trying to make up for less hemoglobin, the blood cells grow larger. While there are no serious immediate consequences of this enlargement, it reflects harmful effects of drinking that in the long run can damage circulation and brain cells.

Source: Strobbe, S., Finnell, D.S., & Piano, M. (In press). Assessment and treatment of alcohol abuse and dependence. In P. Murray & C.S. Savage (Eds.). A Nursing Education Model for the Prevention and Treatment of Alcohol Use Disorders. Rockville, MD: National Institute of Alcohol Abuse and Alcoholism (NIAAA).

Suggested Laboratory Tests for Depression

The following laboratory tests are recommended prior to the initiation of the medication protocol if they have not been obtained within the last six months. Medical illnesses are more common in those ages 60 and over. These labs will help rule out medical disorders that may present signs and symptoms that are also common to depression.

CBC (complete blood count) A complete blood count (CBC) is a calculation of the cellular makeup of blood. A CBC measures the concentration of white blood cells, red blood cells, and platelets in the blood and aids in diagnosing conditions and disease such as malignancy, anemia, or blood clotting problems. The test may be ordered as a part of a routine check-up or screening, or as a follow-up test to monitor certain treatments. It can also be done as a part of an evaluation based on a patient's symptoms. For example, a **high white blood cell (WBC) count** (leukocytosis) may signify an infection somewhere in the body or, less commonly, it may signify an underlying malignancy. A low WBC count (leukopenia) may point toward a bone marrow problem or related to some medications, such as chemotherapy. A medical provider may order the test to follow the WBC count in order to monitor the response to a treatment for an infection. The components in the differential of the WBC count also have specific functions and if altered, they may provide clues for particular conditions. A **low red blood cell count** or low hemoglobin may suggest anemia, which can have many causes. Possible causes of high red blood cell count or hemoglobin (erythrocytosis) may include bone marrow disease or low blood oxygen levels (hypoxia). A **low platelet count** (thrombocytopenia) may be the cause of prolonged bleeding or other medical conditions. Conversely, a high platelet count (thrombocytosis) may point toward a bone marrow problem or severe inflammation.

BMP (basic metabolic panel). The test includes BUN, creatinine, CO2, potassium, sodium, calcium, chloride and glucose. This test is used to evaluate kidney function, blood acid/base balance, levels of blood sugar and electrolytes. BUN and creatinine are waste products filtered out of the blood by the kidneys. Increased concentrations in the blood may indicate a temporary or chronic decrease in kidney function. Both increased and decreased levels of calcium and glucose can significantly affect the person's wellbeing. The concentrations of sodium and potassium are tightly regulated by the body. Electrolyte (and acid-base) imbalances can be present with a wide variety of acute and chronic illnesses.

TSH: Elevated TSH may indicate hypothyroidism in which symptoms can range from the slowing of physical and mental functions, fatigue, lethargy, and apathy in mild hypothyroidism to severely slowed physical and mental reactions, and abnormal fatigue in a full-blown myxedema. Common affective manifestations include dysphoria, psychomotor agitation or retardation, sleep disturbances, crying spells, anhedonia, decreased libido and suicidal ideation. **Decreased TSH** may indicate hyperthyroidism which can include symptoms of weight loss, fatigue, weakness, and irritability.

B12: The most common cause of **decreased B12** is pernicious anemia, a condition that can develop years prior to a decline in the measurable B12. As with other anemias, persistent fatigue is a common sign of pernicious anemia. A deficiency in B12 may also manifest itself by other symptoms such as mood disorders, confusion, and insomnia.

For patients abusing alcohol also recommend obtaining **ALT** and **AST**: Alanine aminotransferase (ALT) (SGPT) and Aspartate Aminotransferase (AST or SGOT) are measures of liver enzyme activity that frequently are the first biochemical abnormalities appearing in patients experiencing liver dysfunction of multiple etiologies. **Elevated ALT and AST** are a reflection of the leakage of these enzymes into the systemic circulation from damaged hepatocytes which may result from medical disorders such as hepatitis and cirrhosis both of which have symptomotology that include weakness and fatigue, anorexia, and weight loss. In addition, hepatocyte impairment may result in decreased hepatic clearance of neurotoxins which can result in hepatic encephalopathy and an accompanying decreased mental alertness and confusion.

Other possible laboratory tests to look for or that may provide useful information:

HEMATOCRIT (HCT): Decreased HCT is an indicator of anemia, which is the result of some underlying disorder, such as chronic infections, cancer, renal and liver diseases, and bleeding ulcers. *Anemia can present with fatigue, depression, anorexia and weight loss.

NA: **Decreased serum NA**-Hyponatremia may result in irreversible brain injury in the elderly, regardless of the primary etiology. Imbalances in NA can be a result of dehydration, which itself can be induced by diuretics and some anti-depressants. Dehydration may initially present with confusion. Hyponatremia is also a risk factor for delirium, which can also be confused with depression in its early stages.

Psychopharmacological Algorithms for the Treatment of Major Depression and Generalized Anxiety

General Principles for Using this Guide

1. Clinical judgment can always override the algorithm.

2. Suggest exposure to recommended agent for six weeks. Clinicians may elect to interrupt a step earlier, e.g. in four weeks, and proceed to the next step depending on severity of depression.

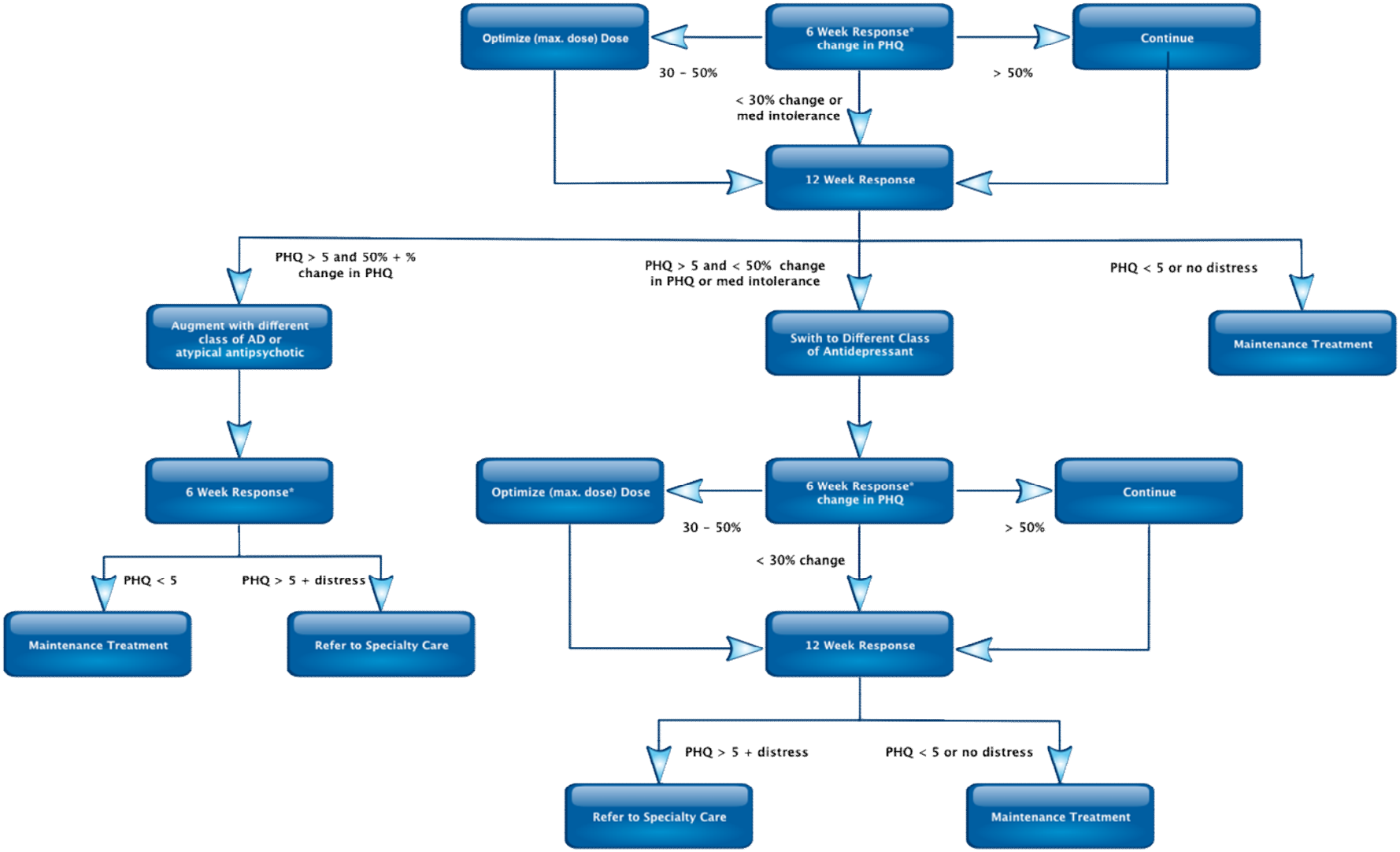
3. Psychotherapy may be used as alternative to pharmacotherapy (Psychotherapy alone) or be combined with antidepressants (augmentation).

4. Drugs that are simpler to implement in primary care are favored over drugs of known efficacy, but which require special procedures. e.g. TCAs should be given lower priority as they may require ECGs and are unsafe in overdose.

5. Treatments that are often poorly tolerated should be given lower priority than treatments that are more likely to be tolerated, even when the efficacy of the latter treatments may be less well-established, e.g., bupropion augmentation of SSRIs should be favored over lithium augmentation.

6. BHPs are strongly encouraged to discuss cases involving pharmacotherapy with the supervising clinician.

Depression/Anxiety Antidepressant Medication Algorithm



Neutraceuticals (Nutritional Supplements)	
This information is provided about claims of psychotropic benefits from these various compounds. Very little scientific data actually supports these claims except for some indications that those starred (*) below may have some value. If the patient is taking any of these, make sure the treatment team is aware.	
PURPORTED PSYCHOTROPIC BENEFITS	**CLAIMS**
357 Magnum maximum strength Caffeine Tablets	Stimulant
44 Magnum maximum strength Caffeine Tablets	Stimulant
5-HTP (Serotonin Precursor)	Precursor to the neurotransmitter serotonin. Relieves depression as most antidepressant drugs with almost no side effects.
Acetyl-L-Carnitine	Reverses decline in the neurotransmitter acetyl-L-carnitine. Increases production of dopamine in the brain. Reverses age associated memory decline.
B Vitamin Complex	Used to improve memory loss from lack of Vitamin B.
Chinese foxglove root	Used for insomnia and used in conjunction with other herbs to treat forgetfulness.
Clover, Red	Used as a "nerve tonic" and as a sedative for exhaustion.
Cordycepa (Chinese Caterpiller)	Helps to adapt to excessive stress; also helps boost stamina and energy.
Cyperus	Used to treat depression.
Darniana	Used to treat depression, anxiety and listlessness.
DHA	Fish oil, which protects the cell membrane integrity of brain cells.

Neutraceuticals (Nutritional Supplements) continued	
EDTA (Oral Chelation Therapy)	Cleanses the blood stream of heavy metals, which can prevent memory problems.
False Unicorn	Used for menopausal depression.
Fish Oil*	Used as a mood stabilizer.
Gaba	Reduces feelings of anger and anxiety in as little as 15 minutes.
Ganoderma	Used to treat insomnia and nervousness.
Gingko Biloba*	Improves small capillary circulation in the brain, which improves cognitive functioning. Lessens "old age related" anxiety and confusion. Used to treat depression.
Ginseng	Helps to control stress-induced high levels of cortisol. Used to treat depression.
Gotu Kola	Mental stimulant. When used regularly it can prevent nervous breakdown, also used to treat a "mental breakdown."
Hawthorn	Used for insomnia and nervous conditions.
Hops	Used for insomnia and anxiety.
Hyssop	Used to treat anxiety.
Inositol	B vitamin used to relieve anxiety and stress.
Kava (Dipper Methysticum**)**	As effective as certain benzodiazapines for anxiety. Also used for insomnia and depression.
Kola	Used to treat depression.

Neutraceuticals (Nutritional Supplements) continued	
Lavendar	Used for relief of nervous tension and stress, insomnia and depression.
Melatonin*	Helps to fall asleep quickly and naturally.
Mugswort	Used for nervousness, shakiness and insomnia.
Mullein	Used as a sedative.
Nutmeg	Used to relieve chronic nervous problems and insomnia.
Passionflower	Used for insomnia and anxiety.
Pennyroyal	Used to treat anxiety.
Peony	Used in combination with other herbs to ease emotional nervous conditions.
Peppermint	Used to treat insomnia and anxiety.
Phosphatidyl Serine	Improves memory
Polygonum	Used to treat insomnia.
Poppy	Used for insomnia and nervousness.
Rosemary	Used to treat nervous disorders.
SAMe (S-Adenosyl-Methionine)	As effective as tricyclic antidepressants, without the bad side effects.

Neutraceuticals (Nutritional Supplements) continued	
Schisandra	Used to treat insomnia and forgetfulness.
Snooze Fast	Safe, effective and fast acting sleep aid.
St. John's Wort (Hypericum)*	Effective antidepressant with almost no side effects; particularly effective for SAD. Lowers cortisol levels and enhances gaba (one of the calming neurotransmitters) activity in the brain.
Scullcap	Immediate relief from all chronic and acute diseases that affect the nerves and also used for insomnia.
Tyrosine	Encourages healthy levels of dopamine and norepinephrine in the brain. Increases low levels of tyrosine.
Valerian	Used for insomnia, anxiety and nervousness.
Vitamin C	Slows Parkinson's Disease.
Vitamin E	Reduces the risk of mini-strokes.
Yarrow	Used for insomnia and anxiety.

Treating Chronic Pain: Clinical Pearls

1. **Begin by accepting patients' report of their pain as truthful**
   No medical test shows pain. Most chronic pain does not correlate with objective findings such as on imaging, but it is still real and can often be treated.

2. **Negotiate goals of treatment carefully before starting and/or suggesting therapeutic trials.**
   Focus on improving the patient's life rather than eliminating their pain. Ask what improvements in patients' functional status (e.g. their work, social interactions, family life, or home activities) would get them closer to the life they want. The patient's active participation in treatment often begins with active participation in setting the goals for treatment. Emphasize that complete pain relief is not a realistic goal and that chasing after such a goal will almost certainly lead to failure.

3. **Assess whether depression is also present.**
   Ask about weight change, sleep, and capacity to enjoy things. Although such symptoms might be caused by chronic pain, treating the depression may be very important and helpful. Tell patients, "I'm not saying that the pain is in your head, but an antidepressant might improve these symptoms and help relieve your pain." If the patient agrees to psychotropics, discuss this with their provider.

4. **Frame the need for an ongoing, exclusive partnership built on trust.**
   Chronic pain treatment works only in the presence of an honest partnership between patient and provider. If the patient is prescribed opioids, explain that opioid treatment of chronic pain carries significant risks and benefits; so regular clinic visits are required. Patients must understand from the beginning that they should not seek other prescriptions or escalate medication dosages on their own.

5. **Of note, chronic opioids should not be the sole treatment in the plan of care.**
   Opioids alone can promote passivity rather than functional recovery. Include rehabilitative treatments (physical therapy and exercise programs) other medications (non-steroidals, adrenergic antidepressants) and alternative medicine (acupuncture, massage) or refer when appropriate.

6. **Watch for signs of opiate abuse.**
   History of substance abuse is the most important early warning of possible abuse. Requests for early refills due to dose escalation, leaving town, stolen medications may indicate current abuse. Reinforce clear guidelines for continued use. Continued failure to abide by these guidelines should prompt tapering off opiates and a switch to use of non-opiate treatments only.

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Pain Medications

ANTI-INFLAMMATORIES--NSAIDS

- Aspirin--OTC
- Ibuprofen (Advil, Motrin)—OTC/Rx
- Naproxen (Naprosyn, Anaprox, Aleve)—OTC/Rx
- Salsalate (Disalcid)—Rx
- Indomethacin (Indocin)—Rx
- Sulindac (Clinoril)—Rx
- Etodolac (Lodine)—Rx
- Diclofenac (Voltaren)—Rx
- Piroxicam (Feldene)—Rx
- Nabumetone (Relafen)—Rx
- Celecoxib (Celebrex)—Rx
- Rofecoxib (Vioxx)—withdrawn from the market
- Valdecoxib (Bextra)—Rx
- Doan's (Magnesium salicylate)—OTC

ANALGESICS

- Acetaminophen (Tylenol)—OTC

MUSCLE RELAXANTS

- Methocarbamol (Robaxin)
- Cyclobenzaprine (Flexeril)
- Baclofen (Lioresal)
- Tizanidine (Zanaflex)
- Carisoprodol (SOMA)—not available at VA
- Valium and related medications

OPIATES

- Tramadol—non-narcotic; related
- Codeine (Tylenol #3)
- Hydrocodone (Vicodin with Tylenol)
- Oxycodone (Percocet with Tylenol, Percodan with aspirin)—short acting
- Morphine—long and short acting
- Methadone—long acting
- Fentanyl—long acting
- Hydromorphone—short acting

OTHERS

- Tricyclic antidepressants (Amitriptyline, Nortriptyline)—affect norepinephrine
- SSRIs—also antidepressants (Prozac, Paxil, Zoloft)—affect serotonin
- Antidepressants that affect both (Effexor, Duloxetine)
- Gabapentin (Neurontin)
- Pregabalin (new)
- Lidocaine patches
- Capsaicin cream

Note:

OTC = "over the counter" Rx = by prescription

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Common Opioid Medication Side Effects		
Side Effect	**Causes of the Side Effect**	**Ways to Manage Side Effects**
Nausea	Decreased stomach secretions, decreased movement of the stomach walls	• Adjust dose • Change medication • Use anti-nausea medications
Drowsiness	Direct effects on the brain	• Adjust dose • Change medication
Constipation	Decreased forward movement in the bowels	• Adjust dose • Change medication • Increase dietary fiber and fluid intake • Use stool softeners regularly • Use laxatives, enemas, and/or suppositories if needed
Sweating	Unclear	• Adjust dose • Change medication • Use of benzotropine – may be helpful
Respiratory depression (breathing difficulty)	Direct effects on the brain	• Decrease dose
Difficulty urinating	Impaired contraction of the bladder	• Adjust dose • Change medication • Use medications that help the bladder to empty
Mood changes/difficulty concentrating	Direct effects on the brain	• Adjust dose • Change medication wait (often improves with time)
Lower sex hormone levels	Decreased production of hormones in the brain that stimulate production and/or release of testosterone and estrogen	• Adjust dose • Taper off medication • Replace testosterone • Replace female hormones (estrogens)

SECTION 3

Sample Clinical Reports

Baseline Report

BASELINE REPORT
CLINIC: Test Clinic

Last name: Patient	**Patient's age: 71**
First name: Test	**Patient's sex: Male**
Patient's race: White	
Date of interview: 2/14/2011 **Method of interview: Phone**	**General health: Very Good**

ACTION ITEMS / INITIAL TREATMENT PLAN:
Reported symptoms consistent with: At Risk Drinking: dependence

If the patient does not attend the appointment below, they will be called by a behavioral health provider to promote attendance.

The patient expressed interest in the following: quit Smoking, considering cut down drinking. We encouraged him to follow up with his provider about treatment options.

We provided educational materials explaining standard drinks and drinking limits and how the patient's drinking can interfere with his health.

ASSESSMENT SUMMARY SCORES AND TREATMENT HISTORY:

PHQ-9 score = 0
GAD-7 score = 0

Standard Drinks per week = 49
Binge Episodes in last 3 months = 90

Psychiatric/pain medications:
Lexapro - Antidepressant (SSRI) , Xanax - Anxiety/Sleep (Benzodiazepines)

Adherence:
He reports taking all prescribed doses of medication in the last 2 weeks.
He did not report taking more or a larger dose of medication than prescribed in the last two weeks.

RESULTS FOR INDIVIDUAL ASSESSMENTS
The remaining sections of the report contain the responses and/or summary information for each assessed domain. The individual responses are based on self report and should be used in context with other available clinical information.

COGNITIVE SCREENING

This patient was screened for cognitive impairment using the Blessed Orientation-Memory-Concentration (BOMC) Test and scored 14, suggesting cognitive impairment.

BASELINE REPORT continued

DEPRESSIVE SYMPTOMS:
Patient did not endorse any symptoms of depression.

PHQ-9
1. Little interest or pleasure: Not at all
2. Feeling down or hopeless: Not at all
3. Trouble sleeping: Not at all
4. Tired, low energy: Not at all
5. Poor appetite, over-eating: Not at all
6. Feelings of failure, guilt: Not at all
7. Trouble concentrating: Not at all
8. Motor retardation, agitation: Not at all
9. Suicidal ideation: Not at all

The PHQ-9 total score (measure of depressive symptoms) equals 0
1-4 = minimal symptoms 5-9= mild symptoms
10-14= moderate symptoms 15-19= moderately severe symptoms
20-27= severe depressive symptoms

SUICIDE SCREENING

The patient was screened for suicidal ideation and was not found to be at high risk (see specific responses below).

Responses to the Suicide Screen questionnaire:
1. In the last year, there was a time when the patient had thoughts that life was not worth living. No
2. In the past year, there was a time that the patient wished he were dead such as going to sleep and not waking up. No
3. In the past year, there was a time the patient reports thoughts of taking his own life. No
4. In the past year the patient reported seriously considering suicide. No
5. In the last year, the patient reports having made a suicide attempt. No

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ANXIETY DIAGNOSIS:
The patient did not meet criteria for a current anxiety disorder.

ANXIETY SYMPTOMS (GAD-7)
The GAD-7 total score (general measure of anxiety) equals 0
0-4 =minimal symptoms 5-9=mild symptoms
10-14=moderate symptoms, 15-21=severe symptoms

GAD-7 (anxiety symptoms reported in the last two weeks):
1. Feeling nervous, anxious or on edge: Not at all
2. Not being able to stop or control worrying: Not at all
3. Worrying too much about different things: Not at all
4. Trouble relaxing: Not at all
5. Being so restless that it is hard to sit still: Not at all
6. Becoming easily annoyed or irritable: Not at all
7. Feeling afraid as if something awful might happen: Not at all

BASELINE REPORT continued

ALCOHOL USE AND SMOKING:
# of drinks per week: 49
# of binges in last 3 months: 90
Abuse/Dependence Diagnosis: Dependence

The patient reported symptoms consistent with alcohol dependence. Reported symptoms include: excessive drinking, withdrawal symptoms, drinking more than intended, failed attempts to quit, substantial time devoted to drinking, impaired activities, and drinking despite health problems.

The patient reported that he currently smokes tobacco products.

ILLICIT DRUG USE:
The patient did not report any significant illicit drug use in the 3 months (including cocaine, heroin, and marijuana).

PSYCHOTIC SYMPTOMS:
The patient reported no hallucinations or delusions.

MANIC SYMPTOMS:
The patient reported no current manic/hypomanic symptoms.

SOCIAL SUPPORT AND EMPLOYMENT
Current marital status: Married/Partnered
Current employment status: Employed full time
Self-reported financial situation: Financially comfortable

The patient reported:
Contact with friends or relatives (including visits, phone calls, etc.): About once a day or more
Past month, people acted inconsiderate or unsympathetic to him: Very often
Friends and relatives make him feel loved and cared for: A great deal

This report is based on a structured interview with this patient. The interview was conducted to assist in triage, document self reported symptoms, and aid in implementing the treatment plan. The staff encouraged the patient to discuss the findings with his provider.

This assessment was conducted by the Integrated Care Team directed by [Director Name]. If you have any questions please call, [Director's Number].

If you have questions regarding this patient's clinical management, please contact [BHP contact information].

Brief Intervention Report

BRIEF INTERVENTION REPORT

Last Name: Tester
First name: Test
Date of Interview: 1/22/2009
Patient's age: 88
Patient's sex: Male
SSN XXX-XX-XXXX

This patient was contacted in order to complete a Brief Alcohol Intervention, a structured psychosocial intervention for patients drinking alcohol in excess of recommended guidelines. Health Promotion Workbooks were utilized to help this patient in reducing their alcohol intake to safe levels. Motivational interviewing techniques were used to discuss the patient's problems, concerns, and ambivalence about their drinking, and to help the patient recognize the risks associated with their level of alcohol use. Issues addressed include the effects of alcohol on health and body systems, the reasons the patient's drinking patterns may be problematic, how modification of alcohol use can result in specific health benefits, and methods for the patient to change their drinking habits.

If you have questions regarding this patient's clinical management, please contact [BHP contact information].

Depression Management Report (Medication Management)

BRIEF INTERVENTION PROGRESS NOTE
CLINIC: Green Team

Last name: Patient	**Patient's age: 42**
First name: Test	**Patient's sex: Male**
Patient's race: White	
Date of interview: 2/14/2011	**General health: Very Good**
Method of interview: Phone	

ACTION ITEMS / INITIAL TREATMENT PLAN:

This patient is being monitored for his response to his antidepressant medication. Please see below for an update on his progress.

RESULTS FOR INDIVIDUAL ASSESSMENTS

The remaining sections of the report contain the responses and/or summary information for each assessed domain. The individual responses are based on self-report and should be used in context with other available clinical information.

DEPRESSIVE SYMPTOMS (PHQ-9)
1. Little interest or pleasure: Several Days
2. Feeling down or hopeless: Several Days
3. Trouble sleeping: Several Days
4. Tired, low energy: Several Days
5. Poor appetite, over-eating: Not at all
6. Feelings of failure, guilt: Not at all
7. Trouble concentrating: Nearly every day
8. Motor retardation, agitation: Nearly every day
9. Suicidal ideation: Not at all

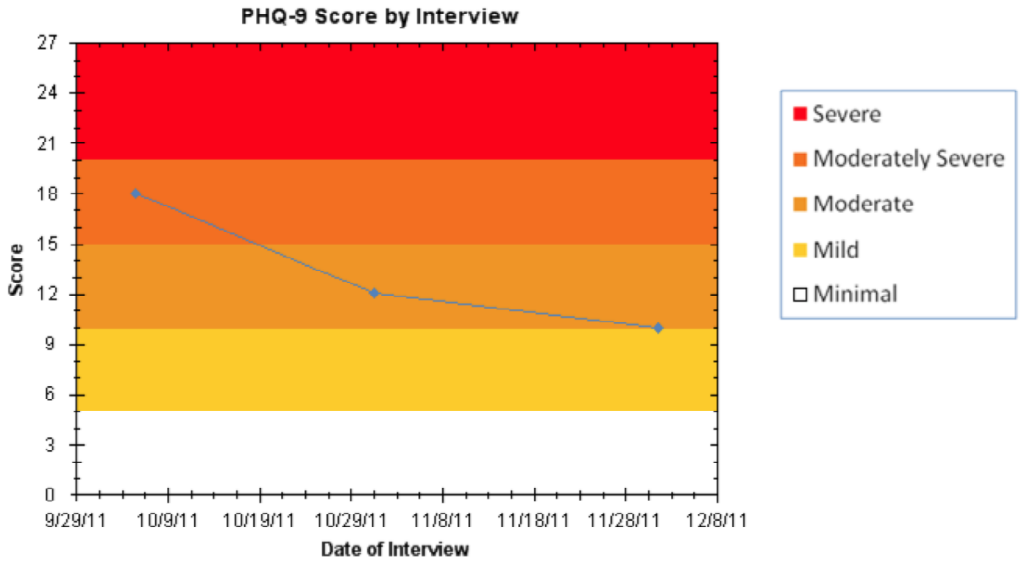
The PHQ-9 total score (measure of depressive symptoms) equals10
1-4 = minimal symptoms, 5-9= mild symptoms
10-14= moderate symptoms,15-19= moderately severe symptoms
20-27= severe depressive symptoms

The patient stated that the depressive symptoms made it somewhat difficult to do her work, take care of things at home, or get along with others.

The current symptomatology represents a decrease of 8 from the initial PHQ score completed 57 days prior.

Depression Management Report (Medication Management) continued

PHQ Score Over Weeks:



MEDICATION TREATMENT, ADHERENCE, ANDSIDE EFFECTS:

The patient is prescribed a psychotropic medication. He reports taking the medication as prescribed.

This assessment was conducted by the Integrated Care Team directed by [Director Name]. If you have any questions please call, [Director's Number]

If you have questions regarding this patient's clinical management, please contact [BHP contact information].

Watchful Waiting Intervention Report

WATCHFUL WAITING INTERVENTION REPORT

Last name: Patient	**First name: Test**

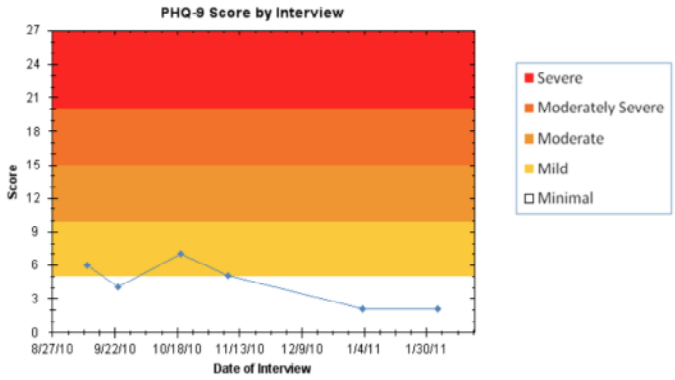
The patient has completed their participation in the Watchful Waiting Module. The patient completed 7 of the 8 weekly interviews. At this time, the patient's depressive symptoms have not been sufficiently disabling to warrant antidepressant treatment or referral for specialty care. If you would like the patient to be referred to behavioral health despite these findings, we can schedule an appointment. Please call us at 555-555-5555 to request scheduling. The following depressive symptoms were reported on 1/27/2011:

Little interest or pleasure: Several Days
Feeling down or hopeless: Several Days
Trouble sleeping: Not at all
Tired, low energy: Not at all
Suicidal ideation: Not at all
Poor appetite, over-eating: Not at all
Feelings of failure, guilt: Not at all
Trouble concentrating: Not at all
Motor retardation, agitation: Not at all

Severity of symptoms (PHQ-9 Total): 2

>5 mild depressive symptoms >15 severe depressive symptoms.

Charted below is the course of the patient's depressive symptoms over the monitoring period. The highest score over the period was 8.



This assessment was conducted by the Integrated Care Team directed by [Director Name]. If you have any questions please call, [Director's Number].

If you have questions regarding this patient's clinical management, please contact [BHP contact information].

SECTION 5

Program Evaluation

Program Evaluation Summary Report

PROGRAM EVALUATION SUMMARY REPORT
Report covers: 2/29/2012 to 8/29/2012
Generated: 8/29/2012

Referrals and Active Baseline Assessments

This report is intended to be used by the clinical team. Data is presented for the selected time frame. Many sections also include data on the matching prior period for comparison. This report is broken into 4 sections:

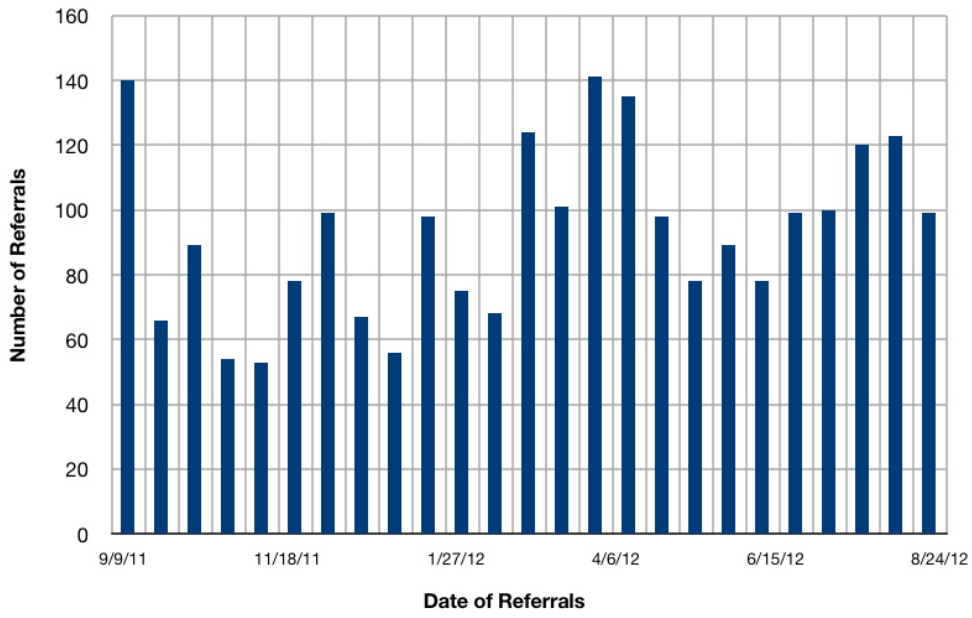
Section A: Referrals and Active Baseline Assessments.
Section B: Completed Baseline Assessments and Outcomes
Section C: Follow Up Care

Section A. Referrals and Active Baseline Assessments
The data presented below reflects the active baseline cases on the last day of the time period. Note, when this report is run for period of time in the past, the cases reflected as active may no longer be active on the date the report is run. The same is true for the prior period included below.

Active Baseline Cases at the close of the selected time period	Current	Prior Time Period
# Active	152	166
# Active > 30 days	34	28
# Active > 14 days & <29 days	31	32
# Active > 7 days & < 14 days	33	25
# Active < 7 days	54	81
# Active not yet contacted	45	62
# Partially completed open episodes	12	7

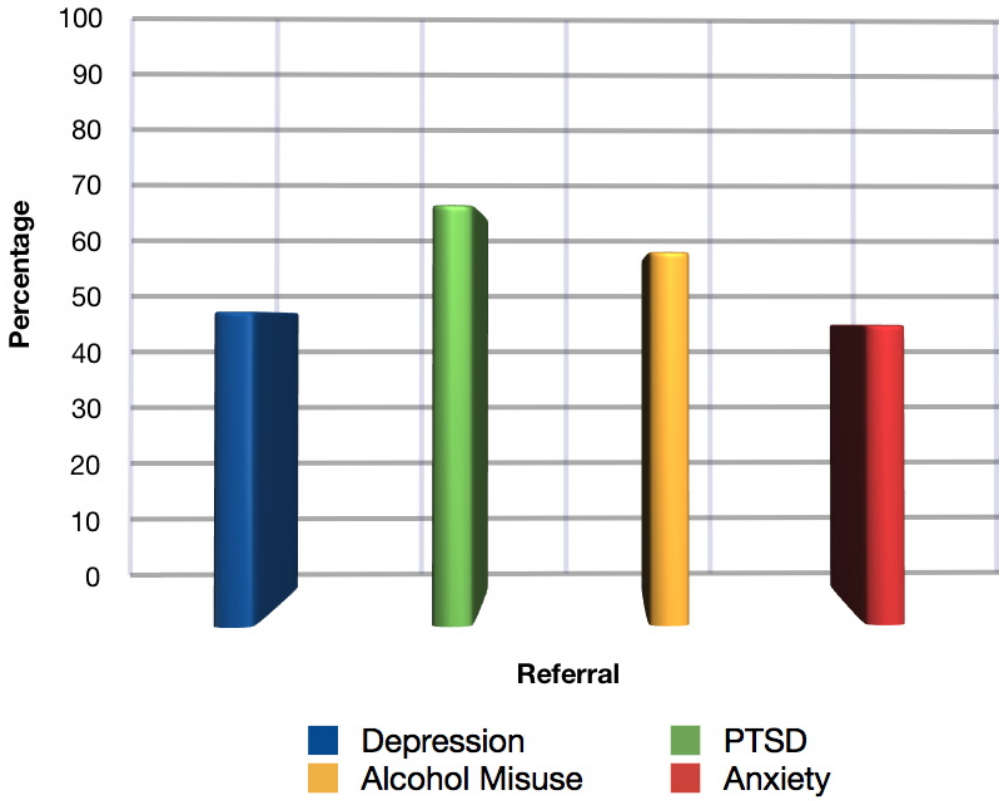
Program Referrals

The graph below reflects the number of patients enrolled in a baseline over the selected time period.



Program Evaluation Summary Report continued

Identified Reasons for Referral



Program Evaluation Summary Report continued

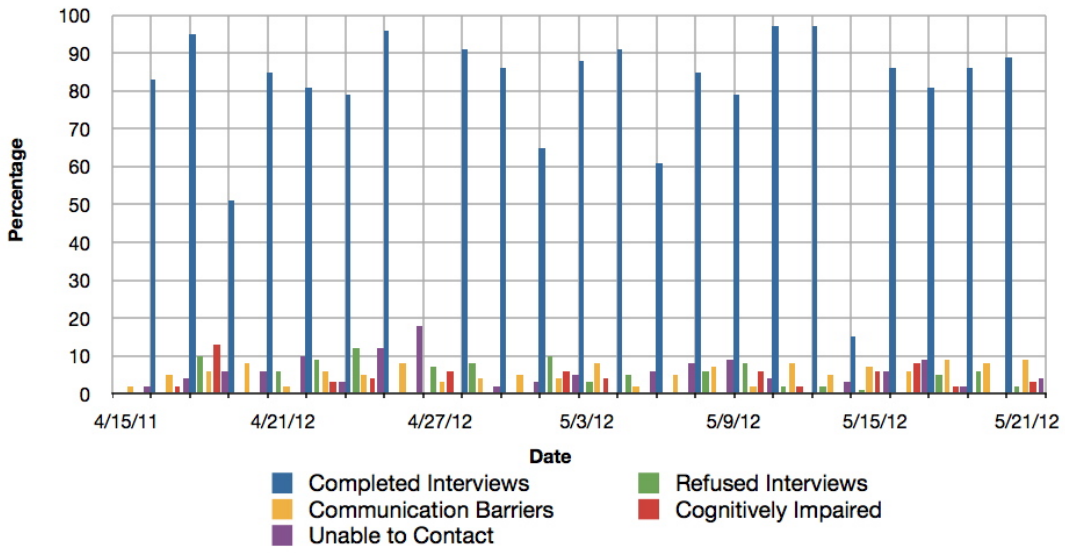
Section B. Completed Baseline Assessments and Outcomes

This section reports on patients who were enrolled in a baseline interview during the designated time frame. It also reports on the prior time period

Completion Rates

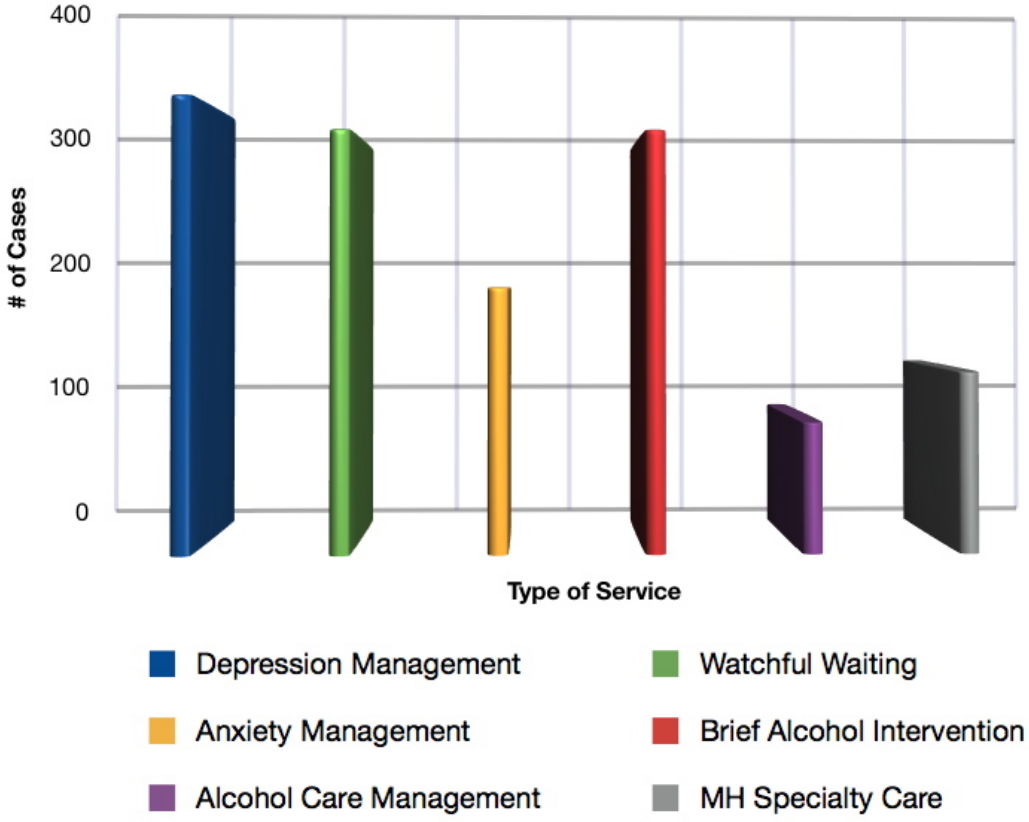
Outcome	# Patients	%	Prior Time Period # Patients	Prior Time Period Previous %
Total # Episodes	**2503**	**100%**	**2513**	**100%**
Completed Interviews	**2005**	**80.1%**	**2040**	**81.2%**
Baseline Interview Completed	1879	93.7%	1858	91.1%
Partial Baseline Interview Completed	80	4.0%	133	6.5%
Cognitively Impaired	46	2.3%	49	2.4%
Refused Interview	**180**	**7.2%**	**113**	**4.5%**
Unable to Contact	**250**	**10.0%**	**232**	**9.2%**
Communication Difficulties	**32**	**1.3%**	**22**	**.9%**
Outcome	**Time**		**Prior Time Period (Time)**	
Median time for completing a baseline interview	23 minutes		21 minutes	
Median # of days the unable to contact interviews were open	39 days		43 days	

Completed Baseline Episodes

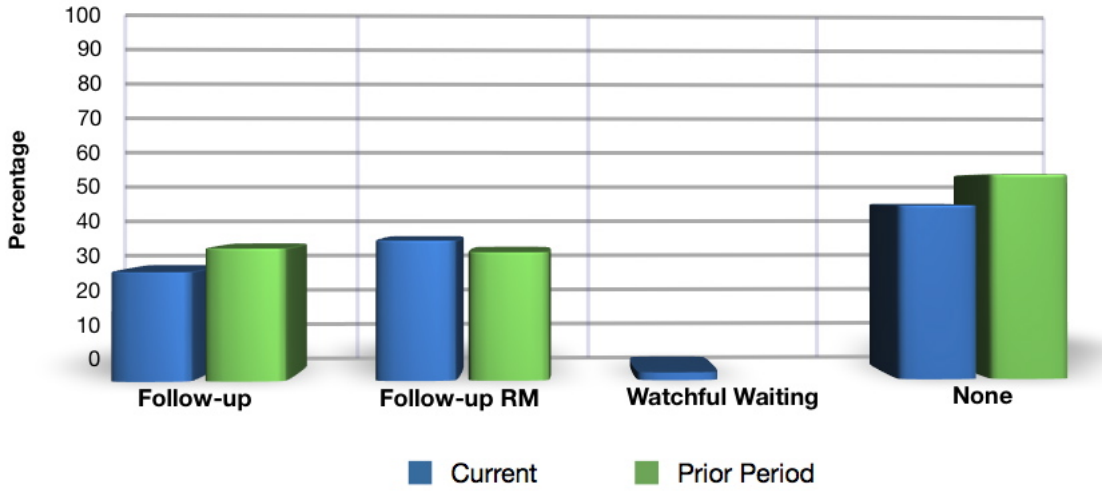


Eligible and Enrolled Services

The graph below illustrates the services that patients were enrolled in after a baseline interview, for the current and prior time periods.



Follow Up Enrollment
The graph below reflects what type of interview patients were enrolled following a baseline interview for both the current and prior time period.
Prior Period: n=2040; Current Period: n=2005



Section C. Follow Up Care

Active Follow Up Care

Active or open cases are presented here, based on the last date in the requested date range.

	Current	Prior Time Period
# Active in Follow Up care	**1173**	**957**
# Active with no interview in 60 days	622	409
# in Referral Management	458	364
# Active in Watchful Waiting	13	0

Completed Follow Up Interviews

Productivity

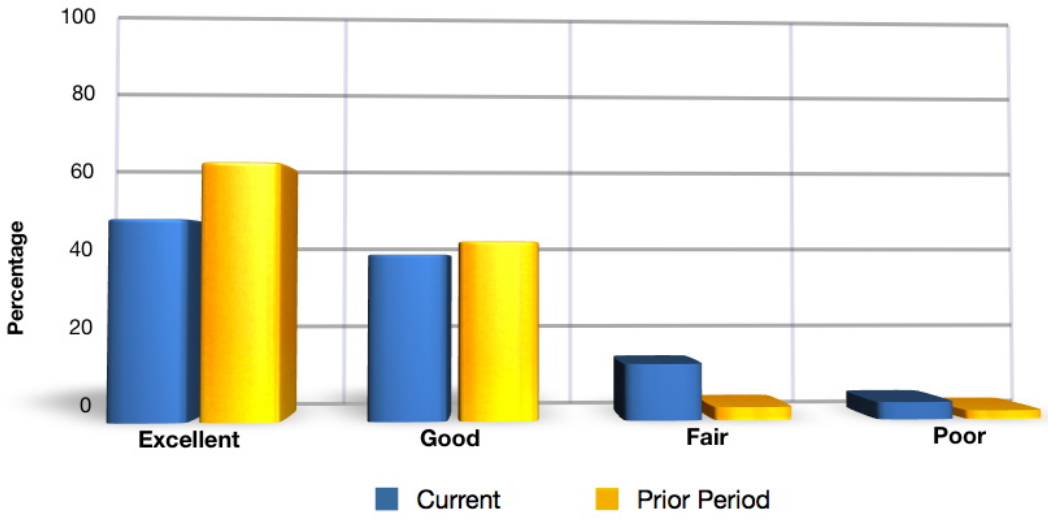
Below find completion rates for Follow Up interviews in the software during the designated time frame and prior period.

	Enrolled in Follow Up Care	Prior Period
Number of patients followed for treatment	603	697
Total # of Follow Up treatment visits	2797	2689
Number that are brief check in	1026	871
Number of patients followed for WW	203	25
Total # of WW visits	67	4

Program Satisfaction

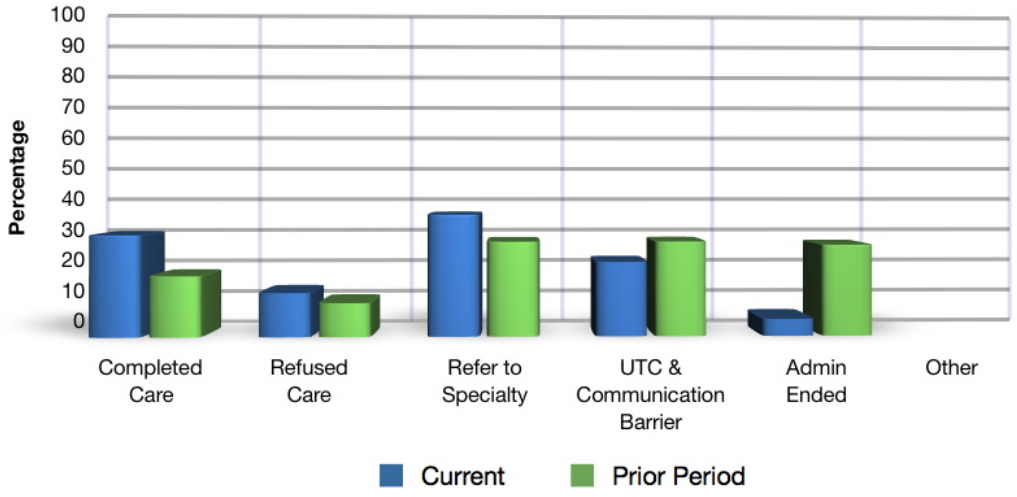
Patients' self-report of satisfaction with the care they received in the program as a proportion of respondents.

Prior Period: n=218; Current Period: n=162



Completion of Follow Up Care

This graph represents the outcome of closed cases during the designated time frame.
Prior Period: n=699; Current Period: n=604

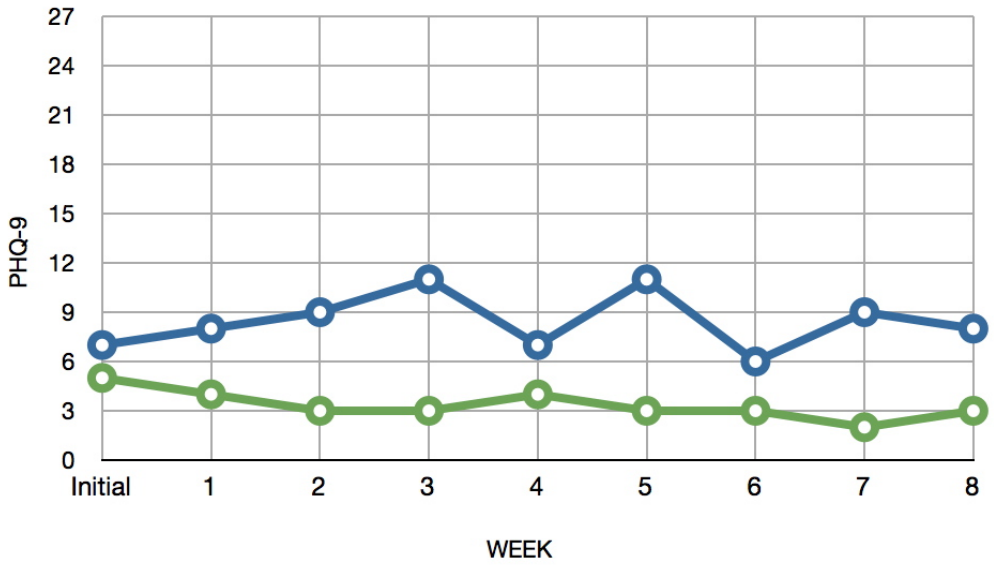


Use of Specialty Care (Referral Management)

	Current Period	Prior Period
Total number Patients agreeing to a Specialty care appointment	**863**	**790**
Patients who attended MH Appt. (%)	69.5%	69.0%
Patients who subsequently refused care (%)	8.7%	7.5%
Patients who didn't attend or those with an unknown status but who are no longer being followed (%)	21.8%	23.5%

Watchful Waiting

	Current Period	Prior Period
Total number of patients completing watchful waiting	**54**	**4**
Patients requiring further treatment	11	0
Patients who requested further treatment	8	0
Patients who were recommended further treatment	3	0
Patients completed with no further care needs	32	4
Patients refused all further contact during monitoring phase	11	0



Steps, Decisions and Needs Assessment for Implementing Integrated Programs		
STEP 1	**Decision**	**Action Item**
Identify the Clinical Services your program will offer. Potential Considerations: • Depression/Anxiety Management • Chronic Pain Management • Brief Alcohol Intervention • Stress Management • Monitoring of Sub-syndromal symptoms • Monitoring of response to newly prescribed psychotropic • Medications • Referral Management • Other _____		
STEP 2	**Decision**	**Action Item**
Identify target clinics/practices/providers, local champions, and implementation sequence.		
STEP 3	**Decision**	**Action Item**
Identify members of local planning committee and meeting logistics.		

STEP 4	Decision	Action Item
Specify target patients and identification procedures. Potential Considerations- • Patients screening positive for program target MH diagnoses/symptoms • Patients with a program targeted MH diagnosis/sx • Patients prescribed an antidepressant or other psychotropic • Medication • Use of available patient registries • Patients referred by PCP or self-referred patients • Other _____		
STEP 5	**Decision**	**Action Item**
Identify potential exclusion criteria and method for assessing criteria: Potential Considerations for Exclusion- • Serious Mental Illness (e.g. Schizophrenia, Bipolar) • Evidence of Psychosis • Severe alcohol /substance abuse problems • Significant Cognitive Impairment • Post Traumatic Stress Disorder • High risk suicide ideation • Engaged in Specialty mental health care • Other _____		

STEP 6	Decision	Action Item
Specify integrated care team members. Potential considerations : • Primary care providers (physician, physician assistant, nurse practitioner) • Program Medical Director • Behavioral Health Provider (e.g., psychologist, nurse, • MSW) Clinical supervisor (e.g., psychiatrist) • Non-professional support staff (Health Technician/Psychiatric Technician) • Technical Support Staff (e.g. software management) • Other _____		
STEP 7	**Decision**	**Action Item**
Specify administrative structure of integrated care team.		

STEP 8	Decision	Action Item
Specify clinical activities of Behavioral Health Provider: Possible Considerations- **A.** Selection of Planned Standardized Measures to be Included in Assessments and the Delivery of Clinical Services. (e.g. PHQ-9) **B.** Initial Assessment • Assessment of psychiatric symptoms, symptom severity and comorbidities o Depression o Suicidal Ideation o Evidence of Current Psychosis o Substance misuse o PTSD o Panic Disorder o Generalized Anxiety Disorder o Sleep Disorders o Pain o Evidence of Excluded Serious Mental Illness(es) o Other _____ • Education and activation • Treatment preference assessment (including family involvement) • Treatment barriers assessment • Psychosocial assessment • Self-management goal setting • Referral of Patients to Specialty Care for clinical status beyond management in primary care setting/program scope/program resources		

(STEP 8) continued **C.** Follow Up Assessments: Consider- • Symptom monitoring • Medication adherence/side effect monitoring • Goal setting/Education • Promotion of Adherence to Treatment Recommendation • Delivery of Manualized Interventions • Self-management monitoring • Brief counseling (e.g., problem solving therapy • Other _____ Other Activities: • Provide integrated care services • Educate PCPs and PC staff • Attend PC team meeting • Collaborate with PCPs on patient care • Marketing programs		
STEP 9	**Decision**	**Action Item**
Specify activities of other integrated program team members: **Primary Care Providers:** • Screen for depression and other MH symptoms • Diagnose MH symptoms within provider's scope of practice and comfort level • Prescribe antidepressants/psychotropic medications • Collaborate with integrated care team • Refer to specialty mental health • Participate in education activities • Other _____ **Clinical Supervisor/Medication Consultant:** • Train integrated program team		

(STEP 9) continued • Provide clinical supervision to BHS and other program staff providing clinical services • Educate PCPs • Provide treatment recommendations to PCPs • Provide consultations (by appointment, curbside) • Accept referrals • Other		
STEP 10	**Decision**	**Action Item**
Develop plan to train integrated program team members: • Attend national/regional training conferences • Supervised self-study • Role playing • Long-distance or local mentoring		
STEP 11	**Decision**	**Action Item**
Specify treatment guidelines. Specify protocols for stepping up the intensity of care for patients not responding to treatment. Guidelines for referral to mental health: • Patient preference • Treatment resistant • Symptom severity • Suicide risk • Psychiatric comorbidity • Non-response • Non-adherence Guidelines for discharging patients from the integrated program:		

• Length of time enrolled • Number of failed trials • Increases in symptom severity or comorbidity **STEP 11)** continued • Number of failed trials • Increases in symptom severity or comorbidity • Good Treatment/Clinical response • Medication management algorithm (formulary adjustments) • The use of the manualized treatment protocols provided in these materials offer evidenced-based treatment guidelines • Likely to be Influenced by the practice preferences of the supervising clinician		
STEP 12	**Decision**	**Action Item**
Specify Suicide Protocol: • Protocol for assessing suicide risk • Protocol for ensuring safety of high risk patients • Clear, written hierarchy of responsibilities of team members		
STEP 13	**Decision**	**Action Item**

Identify or develop implementation tools:
• Clinical information system for patient tracking, initial assessment, and follow-up assessment
• Clinical assessment tools
  o Depression/anxiety/pain symptom severity
  o Suicide risk
  o Psychiatric comorbidity
  o Adherence/Side Effects
  o Cognitive Disability Screen
  o Inclusion of Program-specific standardized measurements
• Brochures and educational materials for PCPs		

• Brochures and educational materials for patients • Training materials for integrated program team **(STEP 13)** continued • Job descriptions and scope of practices for integrated program team members • Clinic/provider names and contact information • Standards for documentation • Consult forms/procedures • Other _____		
STEP 14	**Decision**	**Action Item**
Plan to Collect Quality Improvement Data: Consider- • Workload • # Pts enrolled in program • Mean days from enrollment to discharge • # Patient encounters • Cost per patient **Process Outcomes** • % screened for depression/MH sx in PCP • % screening + • % + screens assessed • Mean days to assessment • % + screens diagnosed • % diagnosed receiving treatment • Mean days from diagnosis to treatment • % treated referred to specialty mental health **Patient Outcomes** • Response/remission rates • Medication adherence • Appointment adherence • Patient satisfaction **Provider Outcomes** • Provider satisfaction		

• % Pts referred to program **Performance measures** • Depression measures • Other program mental health measures **(STEP 14)** continued • Primary care measures • Other _____		
STEP 15	**Decision**	**Action Item**
Pilot, evaluate, and revise.		

Modified from: Fortney J, Pyne J, Smith J, Curran G, Otero J, Enderle M, McDougall S. Steps for Implementing Collaborative Care Programs for Depression, Population Disease Management, 2009; 12: 69-79.