Report to the Legislature

Adult Psychiatric Consultation for Primary Care

Engrossed Substitute House Bill 2315; Sec. 3

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Executive Summary

In 2014, the Washington State legislature passed engrossed substitute house bill 2315 (ESHB 2315). This bill directed the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to develop a plan for a demonstration program to support primary care providers in the assessment and provision of appropriate diagnosis and treatment of individuals with mental health and/or substance use disorders and track the outcomes of the program. Per the legislative direction, DSHS and HCA consulted with experts and stakeholders in the development of the plan. This report provides a description of the proposed plan for the demonstration program, including: recommended program design and staffing model, projected utilization, as well as fiscal estimates including a detailed cost breakdown of the elements of the plan with anticipated state and federal funding and identification costs expected to be funded through new sources of review- both for a demonstration site and for statewide implementation.

The proposed plan seeks to address the gap in the support available to primary care providers treating individuals with behavioral health conditions in their practices. These individuals present along a broad spectrum from mild to moderate anxiety and depression to those with more complex conditions. The expansion of Medicaid dramatically increased the number of individuals with mental health and/or substance use disorder treatment needs entering the health care system through primary care. Options for managing these needs and supporting the individual in the immediacy of the clinic appointment often don't exist.

This plan proposes the provision of telephonic consultation services from a consulting psychiatrist or psychiatric ARNP. Many parts of Washington state lack ready access to the services of a psychiatrist or psychiatric ARNP and the plan helps to stretch the existing resource so that more individuals with behavioral health conditions will be appropriately served in a primary care setting. These specialty provider shortages are even more acutely felt in rural areas and the telephonic nature of this program will help to support these areas.

Recognizing that many individuals would benefit from further mental health or substance use disorder treatment, consultation and support from a behavioral health care manager to provide community resources and linkage to treatment would be made available to both the treating provider and the individual. Many individuals enter into behavioral health treatment through primary care and the plan takes a "no wrong door" approach to increase this access through engagement and referral activities. Additionally, it is expected that these services will act as a bridge to better coordinated and integrated care during a time while a more integrated delivery system is being developed.

Background

A broad spectrum of behavioral health conditions present in primary care. Individuals with mild to moderate anxiety and depression are seen frequently and their needs are usually successfully managed without the need for psychiatric consultation or behavioral health support. Individuals with more complex behavioral health issues, such as someone with severe anxiety and a substance use disorder or treatment resistant depression, require the input of a psychiatric specialist and the support of a behavioral health professional.

Navigating the behavioral health treatment spectrum poses challenges for many individuals and adds a layer of complexity to referrals for many primary care providers. Many individuals living with mental health conditions would benefit from counseling or other mental health service. Substance use disorders often require specialized treatment as well. However for a variety of reasons, the hand-off from primary care to specialty behavioral health services fails. Additionally, most primary care practices do not have access to or maintain on-site behavioral health services to assist with linkage to and care coordination.

Many regions of Washington State lack sufficient access to psychiatric specialty care. Rural portions of the state experience this shortage, and more urban areas suffer from an insufficient number of psychiatrists treating Medicaid-funded individuals. Primary care practices serve many individuals living with behavioral health conditions however some patients present with needs and complexities that challenge the scope and knowledge of traditional primary practice offices. Responding to this type of clinical need often requires specialty consultation and more time identifying and coordinating resources than a typical primary care visit allows. The resources described in this report would improve primary care providers' ability to meet the behavioral health needs of their patients.

Engrossed Substitute House Bill 2315 (ESHB 2315) addresses the need to improve the ability of medical professionals to identify and treat individuals at risk for suicide by providing specialty training in this area. The proposed program provides an additional service to primary care providers aimed at ensuring at-risk individuals receive effective mental health treatment and access specialty services when needed. These supports are intended to bolster the existing system and reach individuals earlier in the course of their illness, before becoming suicidal.

Program Design Description

The plan outlines a set of services that provide access to specialty consultation and behavioral health professional support intended to augment, not supplant existing resources. These services have shown benefits to providers, individuals, and the healthcare system when provided in other settings[1, 2]. The services are proposed in two phases; Phase One in which services are provided in one urban and one rural county on a demonstration basis, and Phase Two with services expanded statewide.

Key Principles of the Plan:

- Address specialty behavioral health workforce shortages by supporting primary care providers who serve people with behavioral health conditions with consultation and resource coordination services;
- Primary care practitioners accessing psychiatric consultation are treating individuals with complex co-morbidities, including uncontrolled chronic medical conditions, alcohol and /or drug use disorders, chronic pain conditions and homelessness;
- Primary care provider visits alone are not always sufficient to support a person with complex co-morbidities, a treatment resistant condition, or non-clinical issues such as homelessness. Care coordination and linkage by a behavioral health care coordinator with knowledge of available local resources, in addition to a psychiatrist or psychiatric ARNP, is critical to engaging individuals who have not previously been identified or who are not currently in specialty behavioral health care with the appropriate type and level of service;
- A range of behavioral health supports are required, and these will vary by primary care practice and the acuity of the individual served. Behavioral health care managers should be regionally based to maximize their knowledge of local resources;
- Consultation, referral, and engagement services augment the existing health care system and do not supplant existing resources;
- Primary care practitioners accessing psychiatric consultation gain insights into treating behavioral health conditions, expanding their capacity to manage these conditions in the future; and
- As a universal service available to primary care providers, patients with many types of public or private health coverage would benefit from this insurance-blind service.

Key Elements of the Plan:

- Provide timely psychiatric consultation to primary care providers serving adults with significant or complex behavioral health needs, including assistance with establishing diagnoses and making medication management recommendations;
- Provide timely access to behavioral health care coordination services with linkages to regional mental health and substance use disorder treatment resources,
- Engage in routine triage wherein consulting psychiatrists and behavioral health care managers assess need for linkage to the crisis system for individuals in acute crisis or at risk of harm to themselves or others;
- Provide follow up contact by behavioral health care managers to track treatment plan compliance and provide care coordination;

Phase One Strategies: Primary Care Psychiatric Consultation Services

Telephonic consultation, referral, and engagement services will be available in one rural and one urban county, weekdays from 8:00 a.m. to 5:00 p.m., consisting of:

Rapid clinical telephone consultation with a psychiatric practitioner, either a psychiatrist or psychiatric ARNP. These services will be provided as follows:

- With a goal of 90% answer rate, primary care practitioners will either get connected directly to a psychiatrist or to a psychiatric ARNP.
- The psychiatric practitioners will routinely assess for acute needs that are best met by the public mental health crisis system.
- Tele-video psychiatric consultations available for primary care practitioners with a psychiatrist or a psychiatric ARNP for individuals whose diagnosis is uncertain and a visual consultation are required.
- The psychiatric consultant will refer primary care practitioners or their patients to the behavioral health care managers when indicated.

Regionally-based behavioral health care managers (BHCM) available to assist with identifying and connecting individuals to local resources will:

- Provide referral to a local mental health or substance use disorder treatment provider as indicated by the individual's need and insurance coverage. Depending upon the need and preference of the individual, the BHCM will schedule the initial appointment.
- Provide post referral and appointment contact to see if individuals attended their appointments and complied with other treatment recommendations, with a report back to the primary care provider.
- Conduct routine assessments for acute needs best met by the public mental health crisis system.
- As needed, deliver supportive telephonic problem-solving counseling for individuals in distress but who are not in need of crisis system services. This support is focused on short term needs, one to two contacts, and maintaining an individual until they can be seen by a specialty provider. Provide referrals and information regarding other social service resources available in the community.
- Be available for resource consultation by primary care providers.

BHCMs function as liaisons between the primary care providers and other services including housing, transportation, food and other essential services. BHCMs can also act as the intermediary between the primary care provider and the consulting psychiatrist. BHCMs may be employees of a primary care network, a rural or community health center or a community mental health agency. Distribution and location of BHCMs will vary by region and will depend

on the employing organization and existing local resources. These Master's level staff will possess a thorough understanding of the regional behavioral health and social services delivery system, and be skilled in identifying individuals in need of crisis mental health services.

Phase One Fiscal Estimates

This model assumes provision of services to individuals regardless of their source of health insurance coverage. It is recommended that a financing mechanism be explored that blends funding from multiple payers, including insurance carriers and public programs like Apple Health. All of these payers and programs would benefit from this efficient model to care for people with significant behavioral health needs. Earlier recognition and intervention in patients at risk for hospitalization or in those contemplating suicide, would reduce both human suffering and health care associated costs.

Phase One

It is recommended that Phase One of this program build upon the success of the existing Partnership Access Line (PAL), a consultation based service focused on pediatric and adolescent behavioral health issues. PAL is staffed by University of Washington affiliated pediatric and adolescent behavioral health experts. Similarly, the adult version of PAL recommended in this report would also be staffed with experts affiliated with the University of Washington. As envisioned, the consultation service would be provided through a contract between the Health Care Authority (HCA) and the University under terms that will allow the HCA to effectively track contractor performance and Phase One efficacy. Being contractually based, and assuming adequate documentation of encounters, these psychiatric consultations will qualify for 50% Federal financial participation (FFP) for costs related to services provided for Medicaid-eligible patients.

For the purpose of modeling, Spokane and Stevens counties were chosen as they contain both urban and rural populations and have suicide rates that are higher than the state average. The model is based on the following assumptions:

- Patient acuity and related behavioral health needs, varies between primary care practices (e.g., some practitioners will use the service more than others).
- The program would be insurance blind, however establishing the possible rate of utilization is based on some understanding of the serious mental illness (SMI) levels in the area.
- The estimated 5% prevalence rate of SMI referred to below is based on sampled data for services provided to patients insured by Medicaid.
- SMI prevalence rates among the population of individuals with non-Medicaid coverage are not included in this staffing model as the assumption was made that unless it is the first presentation to care, they will already have a private provider. Utilization is likely to be slow initially as it will be a new service.

- Phasing the service from a two-county program allows for better estimates of need and utilization as the service is expanded statewide.

The following tables summarize projected pilot program utilization and related FTE need for both psychiatric consulting and BHCM staff levels for the demonstration phase.

Summary of Estimates

The estimates below were developed based on the following information and assumptions. The adult populations in Stevens and Spokane counties were estimated using Office of Financial Management (OFM) numbers from 2015. The numbers of clients receiving Medicaid benefits were obtained from the 'Client by County' report from January 2015. Prevalence rates for mental illness and substance use disorders, behavioral health conditions, were obtained from the 2014 National Survey on Drug Use and Health (NSDUH) and Washington Medicaid claims information. These rates were then applied to the number of persons in each county with and without Medicaid to obtain estimates of the number of persons affected by a behavioral health condition. A 5% prevalence rate of serious mental illness, also obtained from the NSDUH, was used to determine the number of adults eligible for care in the current RSN system. An estimate of 20% was used to reflect the percentage of persons with serious mental illness who were not currently enrolled in RSN level care. These numbers were then combined with the number of persons with mental illness and substance use disorders enrolled in Medicaid and in the commercial populations to estimate the number of persons with behavioral health conditions who might engage services in the primary care setting.

National estimates, NSDUH, suggest 40% of persons with mental health concerns and 10% of persons with substance use disorders seek treatment. Medicaid claims data from 2013 revealed that 17% of adults covered by Medicaid sought mental health services. To account for this range a 30% utilization rate was chosen.

While not all of the persons who seek mental health care through their primary care provider will need a psychiatric consultation, a great many will require behavioral health professional support. As such the 30% utilization rate was kept the same. To determine the FTE amounts required, a caseload of 100 clients at a time for each behavioral health professional and 1000 clients at a time for the psychiatric provider were modelled.

	General Adult Populations			Medicaid Adult Populations					Estimated Utilization			
	Population (Est)	Total Adult MI Pop. (prevalence based est)	Non-Medicaid MI Population[b] (Est)	Adult Enrollment (Jan 2015)[c]	Medicaid Adults w/MI[d]	SMI Sub-Pop[e]	SMI - not seen in RSN[f]	Adults - no RSN services[g]	Non Medicaid Adults - Accessing any MH Services[h]	Other (non-RSN) Medicaid MI Adults[i]	MI Adults, (potential patient base, PCP MH Services[j]	Total Estimated MI Adults Seeking Tx thru PCPs[k]
	Utilization Estimate - Low Scenario											
Spokane	365,834	67,679	51,885	85,371	15,794	790	158	15,162	5,189	15,162	20,351	6,105
Stevens	43,900	8,122	6,710	7,631	1,412	71	14	1,355	671	1,355	2,026	608
Total: Low Est	**514,752**	**75,801**	**58,595**	**93,002**	**17,206**	**861**	**172**	**16,517**	**5,860**	**16,517**	**22,377**	**6,713**
	Utilization Estimate - High Scenario											
Spokane	365,834	141,212	108,259	85,371	32,953	1,648	330	31,635	10,826	31,635	42,461	12,738
Stevens	43,900	16,945	13,999	7,631	2,946	147	29	2,828	1,400	2,828	4,228	1,268
Total: High Est	**514,752**	**158,157**	**122,258**	**93,002**	**35,899**	**1,795**	**359**	**34,463**	**12,226**	**34,463**	**46,689**	**14,006**

NOTES REGARDING METHODOLOGY AND ASSUMPTIONS

Adult MI Prevalence, from national statistics range from 18.5% to 38.6% applied to total estimated adult populations & Medicaid adults

Estimated adult population with mental illness, less estimated adult Medicaid population with MI.

From the HCA "Client by County" report for January, 2015

Medicaid adult enrollees multiplied by national MI prevalence rate

~~%~~ of Medicaid MI adults X estimate of Severe Mental Illness (SMI) for Medicaid population ->>> 5%

Estimated: 80% of adult Medicaid SMI population is served by RSNs 80%

Remainder of Medicaid adults with mental illness, not served in RSN system.

Adults with MI & non-Medicaid coverage who would seek MH services 10% of non-Medicaid adult MI population

All Non-RSN Medicaid adults with MI are assumed in the total PCP mental health consultation patient base

Estimated population of potential patients [sum of f thru h]

Uptake by estimated patient base for PCP MH services 30%

Estimated total potential patient base for PCP MH services (Non-Medicaid Adults + Non-RSN-served Medicaid Adults)

Staffing Estimate Summary – Phase One

County	Total Adult Population in 2015 (estimated)	Adult Medicaid Enrollment Jan- 2015	With Significant mental illness [1]	Projected Usage per month	Psychiatric Consultant FTE	Behavioral Health Care Manager FTE
Spokane	365,834	85,371	6,105	509	1.1	5.0
Stevens	43,900	7,631	608	51	.2	0.7
Total	**409,734**	**93,002**	**6,7113**	**560**	**1.3**	**5.7**

1. Based on sampled adult Medicaid population
2. Estimated Medicaid adults with SMI ÷ 12 months.

The following table illustrates cost calculation and total expected cost for the first and subsequent years of the program. The assumptions are based on a standard overhead expenses for independent therapists, however if the behavioral health care managers and psychiatric consultant are co-located within a community mental health agency or other clinic setting, costs may differ.

Adult Psychiatric Consultation and Referral Phase One Program Cost				
Staff Expenses				
Position	**FTE**	**Annual Salary**	**Benefits [1]**	**Total**
Consulting Psychiatrist	1.3	$180,000	$46,800	$294,840
Master's Level Behavioral Health Care Managers	5.7	$60,000	$15,600	$430,920
Administrative Assistant	1.0	$46,000	$11,960	$57,960
Total Staff Expenses	**8.0**			**$783,720**
Overhead Expenses				
Expense			**Monthly**	**Annual**
Office rent ($15/sq ft x 700 sq ft)			$875	$10,500
Telephone ($100/mo x 12 mos)			$100	$1,200
Electricity/Water ($100/mo X 12 mos)			$100	$1,200
Supplies ($250/mo x 12 mos)			$250	$3,000
IT Services ($100/mo X 12 mos) X 8 workstations			$100	$9,600
Subtotal of Staff and Overhead Expenses				**$809,220**
Indirect Charges (10% of Staff + Overhead Expenses Subtotal)				$80,922
Start-up expenses [2]				
Equipment (computers/printer/fax)				$16,000
Printing Expense (promotional materials)				$5,000
Office Furniture				$13,500
Subtotal - One Time Expenses				**$34,500**
Total Phase One Program Cost for Year One				**$924,642**
Total Phase One Program Cost for Subsequent Years				**$890,142**

1. Benefits assumed at 26% of annual salary
2. Startup costs are one-time expenses (computers, phones, printers, fax machines, support services

Phase Two Fiscal Estimates

Statewide Implementation for Adult Psychiatric Consultation for Primary Care

Statewide implementation of psychiatric consultation services would mean an expansion of personnel to cover all 39 counties. Phase Two should be assessed based on the success of Phase One and with consideration of regional differences and needs. The consultation services should continue as a fee for service contract with the Health Care Authority. They may draw a 50% match of Federal dollars when provided for Medicaid-eligible patients.

Total Adult Population in 2015 (estimated)	Adult Medicaid Enrollment Jan-2015	With Significant mental illness [1]	Projected Usage per month	Psychiatric Consultant FTE	Behavioral Health Care Manager FTE
5,343,271	960,369	75,494	6,291	14.6	64.1

Phase Two assumes a team of 14.6 FTE psychiatrists or psychiatric ARNPs, scheduled in shifts, would be rotating on-call to handle questions about diagnosis, medication, and treatment options from primary care practitioners around the state. It also assumes that up to 64.1 BHCM FTEs would provide engagement, referral, and resource coordination activities telephonically from a regional location, recognizing that some regions would need many more BHCMs than others.

Adult Psychiatric Consultation & Referral State Wide Implementation Estimate	Phase Two - State Wide			
	Staff Expenses - Phase Two			
Position	**Annual Salary**	**Benefits [1]**	**FTE**	**Total**
Consulting Psychiatrists / P-ARNPs	$180,000	$46,800	14.6	$3,315,753
Behavioral Health Care Managers [2]	$60,000	$15,600	64.1	$4,846,101
Administrative Assistant	$46,000	$11,960	5.0	$289,800
Phase Two Staff Expenses			**83.7**	**$8,451,654**
	Operating Expenses - Phase Two			
Expense			**Monthly**	**Annual**
Office rent	($15/sq ft x 7900 sq ft)		$9,917	$119,000
Telephone	($1100/mo x 12 mos)		$1,100	$13,200
Electricity/Water	($1100/mo X 12 mos)		$1,100	$13,200
Supplies	($2800/mo x 12 mos)		$2,800	$33,600
IT Services	($100/mo X 12 mos) X 90 FTEs		$9,000	$108,000
	Overhead Expenses - Phase Two			**$287,000**
	Phase Two Staff + Overhead Subtotal			**$8,729,654**
	Indirect Charges - Phase Two			$872,965
	Start-up expenses [3] Phase Two			
Equipment (computers/printer/fax)				$164,000
Printing Expense (promotional materials)				$51,000
Office Furniture				$138,500
	One Time Expenses - Phase Two			**$353,500**
	Total Phase Two Costs for 1st Year			**$9,956,119**
	Total Phase Two Cost - Year 2 & beyond			**$9,602,619**

1. Benefits assumed at 26% of annual salary

2. These are Masters' Level professionals

3. Startup costs are one-time expenses (computers, phones, printers, fax machines, support services, etc. Phase Two is adjusted for Phase One costs

Agency Resource Requirements

The Health Care Authority assumes that it will have the role of lead agency in implementing the Phase One pilot, assessing the efficacy of the pilot relative to patient outcomes, added value to participating providers, and determining cost effectiveness of the services provided. HCA anticipates one Medicaid Assistance Program Specialist 3 (MAPS 3) FTE would be needed to develop a detailed plan for implementation, drafting the contract for providing the BHCM services, coordinating consultations with participating providers and the program, and providing information regarding services available under the pilot to stakeholders. In addition, the MAPS 3 position would be responsible for monitoring, evaluating, and managing contractor performance. The MAPS 3 staff would also lead efforts to coordinate with existing program elements, and report on the feasibility of establishing these services statewide. The estimated annual cost for this FTE resource is summarized below:

HCA Staff Estimate (1.0 MAPS 3 FTE)	FY 16	FY 17
Salary	68,000	68,000
Benefits	20,000	20,000
Goods & Services	15,000	15,000
Travel	3,000	3,000
Capital Outlays	8,000	0
Total	**115,000**	**107,000**

Monitoring Outcomes

Due to the nature of behavioral health conditions, improvements in functioning are not always demonstrated in the short term. As a result, process measures and intermediate measures of improvement will be used. Measures will include:

- The number of calls received by the behavioral health line and the BHCM;
- The percentage of calls answered by a live person;
- Follow up rates for individuals referred to other services;
- For providers who report care coordination for individuals and more than a single specialist consultation, changes in the severity of depression or anxiety scores will be collected;
- Primary care provider satisfaction with the service;
- Behavioral health, professional and consulting psychiatric provider satisfaction with the model; and
- Emergency room visits and mental health related hospitalizations in the areas served.

Closing Remarks

Behavioral health conditions are commonly encountered in primary care practices. Most primary care providers are well versed in the care of individuals with mild to moderate

depression and anxiety. The needs of individuals who present with more complex or acute behavioral health problems are usually not met in the time available or with the resources found in primary care settings. The plan outlined is this report offers a phased and focused approach to help primary care providers better manage patients with complex behavioral health conditions. Like persons with diabetes or heart disease, individuals with behavioral health conditions require specialty consultation and active supports to help them manage their illness. The resources identified in this plan will help primary care providers extend their ability to manage newly insured and established individuals with complex behavioral health needs.

NOTES

1. Hilt, RJ, Romaire, MA, McDonell, MG et. al. The Partnership Access Line: Evaluating a Child Psychiatry Consult Program in Washington State.

JAMA Pediatrics. 2013; 167(2): 162-168.

2. Katon, Wayne and Unutzer, Jurgen. Consultation Psychiatry in the Medical Home and Accountable Care Organizations: achieving the Triple Aim. *Gen Hosp Psychiatry*. 2011: 33(4): 305-310.

3. Health of Washington State, Washington Department of Health, Suicide. Updated 04/17/2013.

http://www.doh.wa.gov/Portals/1/Documents/5500/IV-SUI2013.pdf

Appendix 1

Case Scenarios and Impact of Psychiatric Consultation

The following case studies help illustrate some of the ways in which individuals with behavioral health conditions present to primary care providers and how these consultative and support services would help facilitate their stabilization and improvement. Many of these individuals have acute needs and require more time, expertise and support than a 15 to 30 minute office visit can afford. Access to specialty behavioral health providers, psychiatrists and psychiatric ARNPs, can be a challenge, even in urban areas for those who are well insured. Outside of the community mental health agencies in rural areas, access to behavioral health care is quite difficult to acquire. Equally important is access to a behavioral health specialist, a Masters level mental health provider who can help direct individuals to local resources, deliver brief supportive counseling, and ensure care coordination across service areas.

The complexity of a person's underlying condition indicates the level and type of intervention needed. These scenarios address a continuum of individual need and provide the two most critical resources for primary care practitioners: immediate advice on diagnosis and/or medications, and timely referral to behavioral health resources.

Scenario One: Making critical medication decisions for an unstable individual with a long history of mental illness.

Mary is 33 years old. She was diagnosed with bipolar disorder six years ago and has had prior episodes of both severe depression and mania. She also has a history of alcohol use disorder that required inpatient treatment in the past. Today, Mary presents in a manic state, reporting that she hasn't slept for days, but she has also been using methamphetamines. She has gone back to drinking and taking sleeping pills, but they have not helped her sleep issue.

Mary's primary care provider knows her well. She is not reporting thoughts of suicide, so emergency mental health services are not needed. She has been in the RSN system before but refuses to return, because she doesn't want to go to a community mental health agency and for people to perceive her as having a mental illness. She has been prescribed complicated combinations of medications in the past to control her symptoms, so a consultation with a psychiatrist is needed to help recommend a suitable regimen. She reports having attended 12 step recovery meetings and found them helpful. She is considering starting again, but she can't remember where the meetings are.

Mary's acute mania and active substance use complicate her treatment planning. Calling the psychiatric consultant phone line with Mary in the room allows the primary care provider to discuss Mary's condition, the medications she has tried before and to come up with a recommendation for medications to start today. It also allows Mary the opportunity to actively

participate in her treatment. Mary is informed that she will be contacted by the behavioral health professional. Several days later the behavioral health professional calls Mary back to see if she has followed up with the plan and to give her information about local 12 step meetings. The behavioral health professional then contacts the primary care provider to assist with care coordination.

<u>Scenario Two:</u> Managing treatment resistant depression to prevent a family from losing their house.

Mike is 44 years old. He is married and the father of two. About four months ago he was diagnosed with depression. His symptoms were not classic, but after a series of normal labs and no other explanation, the diagnosis seemed fairly certain. He has been treated with two different antidepressants but has not improved. Mike is not currently nor has he been suicidal at any time. He reports his family is too important to him to ever leave them. Despite this reassurance he is feeling increasingly guilty about not being able to provide for them.

Two weeks ago he was laid off from his job due to repeated absences. His wife works but does not make enough money alone to pay their bills. They are two months behind on their mortgage. Mike comes in today asking if there is anything he can try to feel better. From a clinical standpoint, Mike has treatment resistant depression. Drug combinations are required that are beyond the scope and experience of most primary care providers. To access specialty advice, the primary care provider calls the adult behavioral health line. Mike's case is reviewed with the psychiatrist and a plan is made for a follow up tele-video visit later in the week between the psychiatrist, Mike, and his primary care provider. The psychiatrist wants to assure the diagnosis is correct and get some additional information about Mike's past and his family history. An appointment is also set up with the behavioral health specialist after the tele-video visit to see if there are any available resources in the community to help Mike and his family during this stressful time.