The time is now 12:30 PM Eastern. The start time for today's broadcast. The topic today is Behavioral Activation an Evidence-Based and Cost-Effective Intervention for Depression. And now, without further ado, I would like to turn things over to your host, Doctor Adrienne Mims with Alliant Quality. Doctor, the floor is yours.

Thank you very much and good afternoon everyone. Welcome to our program today. I think that you will find that it's very helpful to you as you're embarking upon improving the detection and management of depression and risky alcohol use in your practices. I think that you will find this quite important.

On our next slide, we have information for you regarding how you will do billing for your work. We are available here at Alliant Quality to provide expertise in giving you information on the appropriate billing codes that are listed here. Please feel free to reach out to us and you will see information at the bottom of the slide about the specifics regarding coding. It's important that your patients are screened for depression on a yearly basis. You can do this and it is included in the initial preventive physical exam. It is not included as part of the annual wellness visit so you can also provide that code when you do the annual wellness visit. Thank you.

Without further ado, I would like to bring to you our featured guest speaker today Dr. Paula Hartman-Stein. She is a Geropsychologist, healthcare educator and journalist covering Medicare issues for the national psychologist newspaper. She has also edited two books, there entitled Enhancing cognitive fitness in adults and innovative behavioral healthcare for adults. She has over 30 years of experience in direct patient care and many settings including primary care, hospitals and private practice. She has appointments at current academic centers as associate professor for psychiatry at Northeast Ohio medical University. Senior fellow at the Institute for lifespan development and the University of Akron, she's in the division of gerontology. She is also on faculty at the integrated primary care certificate program at the University of Massachusetts medical school. She is an active advocate for quality healthcare since 2007. She currently serves on the depression and Elder maltreatment screening technical expert panel for CMS. Without further ado, I would like to have you welcome Dr. Paula Hartman-Stein.

Thank you very much Dr. Mims, and welcome to the audience who is listening to this today. We will be talking about a type of strategy that can be used rather easily in primary care practices and that is called behavioral activation.

There are a number of objectives I would like to achieve today by the end of the program I would like you to understand the elements of what's called behavioral activation or BA for short it's been used in many research studies treating adults as well as older adults. I want you to understand how activities and moves is linked as well as the efficacy of this procedure even compared to other inventions. I will talk about one of the more recent rather large scale studies done in the UK which demonstrates the cost-effectiveness of the procedure I will be giving you a tool today that you can easily find on the Internet if you would like to have this in your toolbox when you are seeing depressed patients.

Quickly, clinical depression, we all know it's a fairly common and it's a debilitating disorder. I didn't know this until I did background work, it's the second largest cause of disability throughout the world. The most research has been done with two interventions, pharmacological, via antidepressant meds and on the non-Pharma end the cognitive behavioral therapy interventions. Those have the most research done on them. That there are limitations for both of these types of interventions. There are side effects of course from medications. People will stop the medications. They can cause sexual dysfunction, appetite

changes, increase of weight etc. People get discouraged and they will stop the medication and there is a relapse when that is done. Many have advocated in the psychological sciences to use CBT, cognitive behavioral therapy. Research has shown it's as effective as the antidepressants and they provide some protection against the relapse. But it is relatively complex to administer and some studies have suggested that the efficacy depends on the skill level of the therapist. We know that due to economic factors in the United States, skilled mental health therapists are not available in all health care settings and of course in primary care practice that is really where most of the depressive disorders, mental health disorders are treated.

We have behavioral activation as one easy to use strategy. What is it? It manages depressive symptoms by engaging in meaningful positive activity. Now, this isn't just something from it out of the air. It was really developed back in the mid-70s, one of the leading people to write about it was a researcher named Peter Lewinsen. He talked about it and wrote about it as a functional approach to depression and people with depression act in ways that maintain their low mood and it locates the origin of the depression basically in the environment. Behavioral activation theory do not deny biological factors or cognitive factors as contributing. But the way that it works, this is a good schematic to show you, the idea of the theory behind it is that a lowered mood regardless of the reason can lead to a decrease in activity of any kind. Which of course means a decrease in pleasant activity resulting in even lower mood. I call this, this is my term, the circle of inertia. It is breaking this inertia even in a small way. That's what behavioral activation is in essence. According to the BA theory, behaviors most often function as avoidance mechanisms. Maybe the person is trying to cope with a stressful life event, but their behavior is a result in a decrease in positive reinforcers in their life. That's all of the theory behind it.

So again, why can this improve mood? It increases how frequently behaviors are engaged in that lead to something positive. We can have our patients or encourage them to do activities that feel good or are pleasurable or make them feel good because they have accomplished something that they want to accomplish. It's not just getting people to have a treat, eat ice cream cone or even take a walk. Those can be helpful of course but also it is encouraging people to do something that they want to accomplish. That they feel they've been, that the clothes closet or the drawer that has not been cleaned out, maybe accomplishing that is something they have been thinking about for a long time that they have not had the energy to do it.

Why do we recommend BA as a strategy? First of all it is simple to understand. It's relatively easy to deliver although I will tell you that motivating a depressed patient is the hardest part. It's as effective as CBT. You don't need a great deal of expertise in mental health training to be able to do it. It's nonjudgmental. CBT, we talk about people engaging in thoughts that are distorted. There is a term called cognitive distortion. In behavioral activation we don't use that language. It's well-suited for primary care and all types of community settings. It can be delivered along with medication or as a standalone intervention.

The steps are, you review the patient's symptoms. You can talk to the person about how mood and activity are linked. You can say to the person, to your patient, when you give me an example of something that you like to do or that you have like to do in the past and when you do that how do you feel? You may have to drag yourself out of bed to go to your grandchild's game but once you're there how do you feel? You try to get the person to see how their mood changes when they are doing something that they typically have liked. When people are depressed, they have what's called anhedonia the root word hedonism is pleasure, ant means without, so without pleasure. They don't find these activities as pleasurable but once they get rolling in them and doing them that often times their mood lifts. All of us can identify with that. Every human can understand that, I believe. You want as the

interventionist, as the person that's helping your patient, you want to ask them what are some behaviors that you have enjoyed in the past or that you would like to do? On the slide it says consider easy, medium and difficult activities. Sometimes people come up with -- for example I had a patient who said I want to be able to get a ticket to fly to my daughters house in California. I thought that was a rather complex or difficult activity but it was her goal so I'm not going to dissuade her, but I wanted her to start with something a little simpler at the beginning and have some success. Here's an acronym, SMART, you want the goal to be specific and measurable so that the person as well as the provider knows when it's accomplished. It needs to be attainable, that is it's doable, it's realistic and it is consistent with the person's values. It's time limited. If you say I want to exercise, let's do a more time-limited in the next week or two what do you feel you can accomplish. Sometimes walking to the mailbox is all you can do. I had one lady who said to me and this was realistic, she said I barely move. My husband brings me my meals. I sit in a chair and I look at the computer all day but I'm still really depressed. We talked about her moving and she agreed she needed to move more. If I said to her you have to go out and get the mail it would have been overwhelming to her. She came up with the idea of just walking from the bedroom to the office, her home office to the living room twice a day. That sounds pretty easy doesn't it, but to her that was an accomplishment.

Choosing the goals can be challenging. Sometimes people are so depressed they cannot even generate ideas. This is a tool, you can put in your toolbox, look it up on the Internet. There are many different pleasant events scheduled. This is one that I've used because I've worked with a lot older adults in the last 10 or 15 years. This California older persons pleasant event schedule is one that I have liked. It's developed by Dolores Gallagher Thompson and her husband Larry Thompson. It's been utilized in a number of settings and it has been translated into Spanish, so it is readily available. Linda Teri and her colleague Rebecca Logsdon on the West Coast, were the first ones to come out with the pleasant event schedule and they are readily available on the internet.

So let's review the steps. Your patient is depressed. Let's say the person has been on antidepressants and when you do the screen the depression is still pretty high. Should you just increase the dose? I would say you can consider that but I would say adding behavioral activation would be my recommendation. Some people don't want to be on antidepressants. Here's a step and they don't want to go to a mental health therapist. That's okay too. If you can work with them in your primary care setting, this is so doable. You want to be realistic about identifying an achievable goal. Asked the person to come up with examples of either pleasant activities or at least meaningful activities. What do they want to accomplish? You can use one of these pleasant event schedules, have it in your desk. This is so important, to reinforce a person's effort when you see them in person or if you are able to make phone calls. And you need to reassess their depressive symptoms during their visits to you.

Over 10 years of research have come out of what's called Healthy IDEAS. It's a protocol that was developed at [inaudible] Medical School in Texas from grants from the Robert Wood Johnson foundation Healthy IDEAS. IDEAS stands for Identification of Depression and Empowering Activities for Seniors. There is a specific protocol. It's very specific. I'm a certified trainer in Healthy IDEAS. I started in Ohio and I've done training in North Carolina as well. It's a program used really throughout the country. We have lots of background research and this, Healthy IDEAS is specifically for older, frail people receiving home care, originally and attending senior centers. So, there's a lot of research and the interventionists, the therapists have been the nurses or case managers who go into the home. These are not PhD psychologists doing the strategy. I want to point out and I do have on the reference list a couple articles about Healthy IDEAS. The point is that it works. Even for the most frail of people.

I want you to know that this exists and it was a study published in 2016, in The Lancet, an English medical journal. Really an impressive study. They used three primary care sites. Had over 400 patients not older adults, the average age was 44. They went up I think to the 70s, I'm not positive of the oldest one. This is interesting that more than half of the people had one or more comorbid anxiety disorders. The majority were treated in the primary care settings. It was found that behavioral activation when they looked at the outcome measures it was found to be just as effective as CBT.

I wanted to point out that the people that were in the study were not easy to treat depressions. The average number of depressive episodes was seven. Seven discrete episodes of depression over a number of years. That means these are tough cases, my conclusion is. The length of treatment, the sufficient "dose" of therapy, that means number of sessions, was about eight. The primary outcome measure was PHQ-9, done on a yearly basis. It was found to be as effective.

20%, in every research study I've read about depression you always have a group of people that don't respond. In this study same thing. 20%. That that means 80% were responding which is a pretty high number in my book. I would characterize the 20% that had no improvement as perhaps having personality disorders or what is also referred to as character or logical depression. The point here is that in the large scale study done in the UK, BA, behavioral activation, is appropriate as a front-line treatment for depression. With a lot of potential to improve reach and access to therapy around the world. It's pretty impressive.

In the last few minutes we have, I want to just quickly give you some concrete ideas about this. I had a gentleman in his early 70s that had Parkinson's. And depression related to the Parkinson's. He had been a teacher and he was what we used to call a shop teacher. If you're old enough and have heard that term; I'm not sure what they call it today but it's woodworking. He had a workshop in his home that he told me was very cluttered. This is a gentleman who moved very slowly and he talked very slowly. But he was very frustrated with the fact that he had not cleaned out his workshop since he had retired. I thought that was a fairly lofty goal. But he said no, that was his goal. He came in to see me a number of times and actually was in a group that I had going on at the time. I said to him, John, how are we going to know whether you have really accomplished this? He said, easy I'm going to take a picture. A before picture. I promise that when I come back, it was a month or six weeks later, I will come in again and I will show you what I accomplished. By golly, that guy did it. It was most impressive. It's not that his workshop was spick and span, but it was clearly to the eye you could see the improvement and he was very proud of himself. I was not doing cognitive therapy with him, we weren't doing psychodynamic therapy, it was purely behavioral activation. But he was accountable to somebody, he was accountable to me. We had good rapport that is an important element in all of this.

One other quick example, you can use behavioral activation with people who have dementia as well. Certainly mild even moderate dementia. How do I know this? I've worked with a number of people with moderate dementia who had caregivers who talk about how depressive the person, the patient, is behaving. So with the help of a caregiver, we came up with some behaviors that the person with dementia had liked to do in the past here is a picture of one lady who love to look through her picture albums of her grandchildren but have not picked up an album in a long time. This was something that her caregiver regularly did, brought out the albums and they would spend 15 to 30 minutes a day looking at the pictures. Another case was somebody, the woman had been a good cook because of her moderate dementia could not generate the recipes that she had before. Her caregiver said, I will put everything out and I will have her do certain elements of the food prep. This has been used in Montessori-based methods of working with people with dementia. Very effectively. When we tested

and looked at the persons depressive symptoms, in both of those -- in all three of the cases the mood was lifted by simply doing activities once pleasurable and meaningful.

Thank you. We've got two minutes left. I'm going to go ahead and turn it back over to Doctor Mims to conclude the session.

Thank you very much Dr. Hartman-Stein. This is been a wonderful program and something that we can use right away within our practices thank you for sharing. We have a few upcoming events and if you need any help with registering for those please feel free to reach out. Our February 16 that is coming up is an excellent one. It's looking at how you can work with the entire healthcare team as a model for addressing conditions. Not just behavioral health conditions but many of those medical conditions too. Doctor Paul Ciechanowski, I was able to hear him do a presentation on this topic last month and I find it especially if you are in a closed system like an ACO or a [inaudible] system, it would be outstanding for you. For those of you who are in solo practices or group practice I'm sure that you will learn a lot. Thank you very much for being here today. And again thank you to our speakers.