MidAtlantic Path Forward
CoCM Summer Lunch Series

www.mhamd.org/pathforward

- Shared experiences implementing/sustaining collaborative care programs
- 3 virtual sessions - 12-1pm, recorded and shared
  - Two presentations: 15-20 minutes each, followed by Q&A
  - Organizations in and outside of MD, with varying profiles
- Focus on
  - Startup, funding, leadership buy-in/support
  - Workflows & Training
  - Barriers and solutions

OSI BALTIMORE

Leonard & Helen R. Stulman CHARITABLE FOUNDATION

Johnson & Johnson

PATH FORWARD

Focus: a few scalable, high -impact reforms to improve access to MHSUD care

AMERICAN PSYCHIATRIC ASSOCIATION

BOWMAN FAMILY FOUNDATION

THE GOODNESS WEB
Great Leaders | Big Hearts | Bold Bets

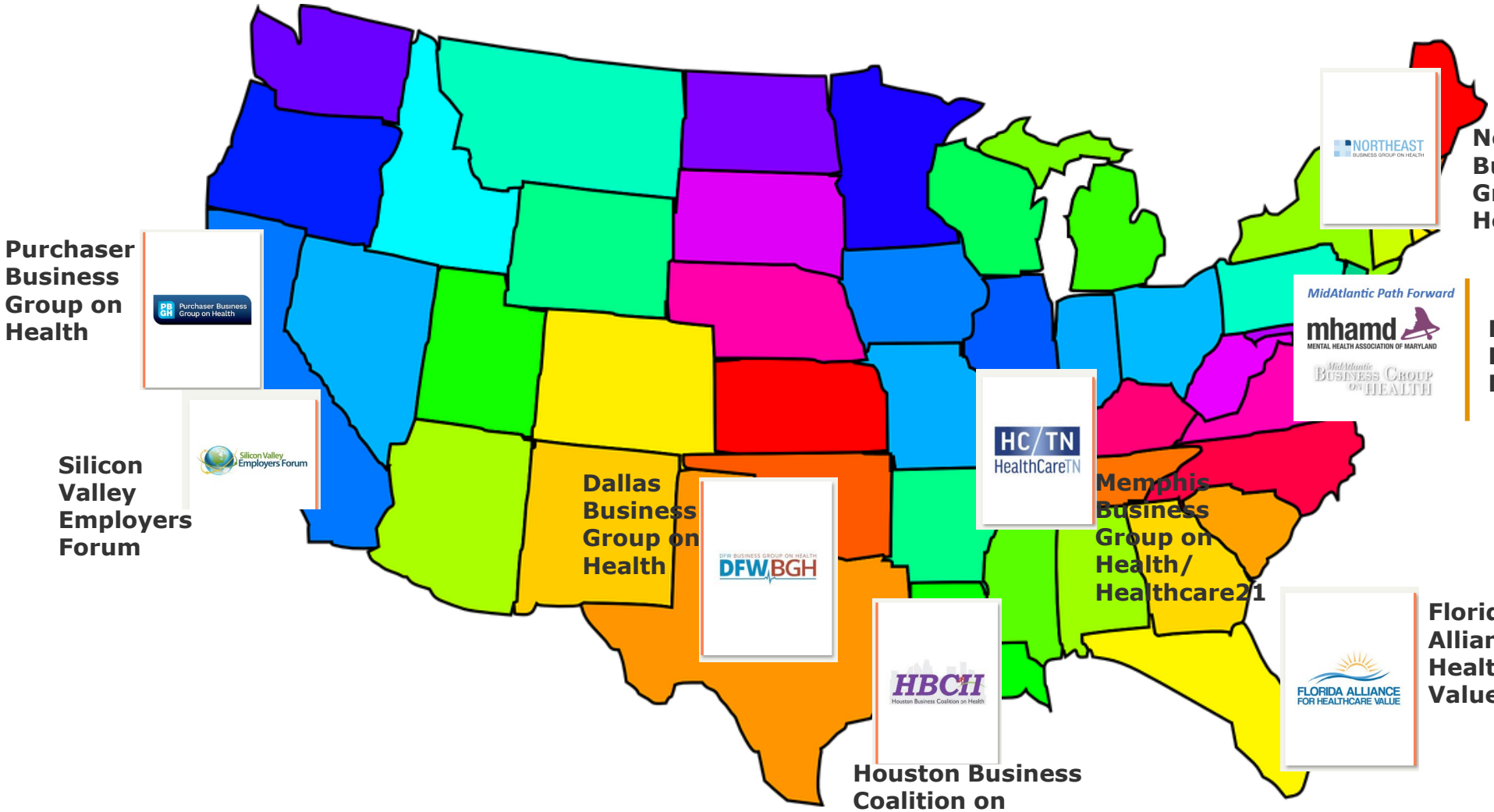
HRPA HR POLICY ASSOCIATION®

JED
The Jed Foundation

MEADOWS MENTAL HEALTH POLICY INSTITUTE

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

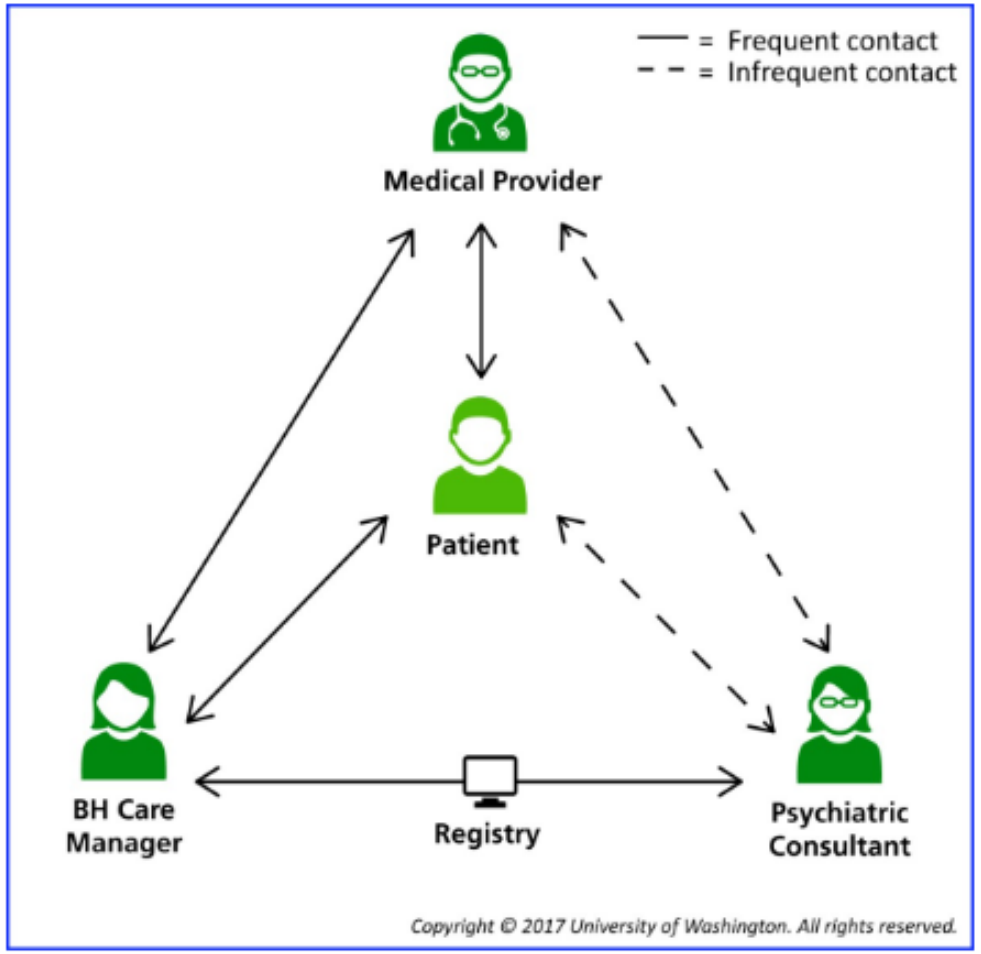
REGIONAL IMPLEMENTATION PARTNERS



The Collaborative Care Model

PCP maintains treatment responsibility for patient

Evidence-based medication or psychosocial treatments



Case consultation, treatment adjustment for patients not improving as expected

Today's Session

Primary Care Coalition, Montgomery County, MD

Sarah Frazell, LCSW-C

Director of Behavioral Health Programs, overseeing the Montgomery Cares Behavioral Health Collaborative Care Program.

Intermountain Health, Salt Lake City, UT

Janelle Robinson, FACHE, MBA, MHA

Behavioral Health Service Line Director within the Medical Group, serving as the behavioral health expert guiding operations of behavioral health services throughout the health system.

Mason Spain Turner, MD

Senior Medical Director for Behavioral Health, focusing on strategic innovations in behavioral health care delivery that enhance quality, clinical excellence and access, integrating behavioral health and primary care and other innovative technologies to expand patients' access to treatment.

Montgomery Cares Behavioral Health Program (MCBHP)

Sarah Frazell, LCSW-C, Director, Behavioral Health Programs

primary care coalition

8757 Georgia Ave, 10th Floor
Silver Spring, MD 20910
www.PrimaryCareCoalition.org

Primary Care Coalition (PCC)

Primary Care Coalition (PCC) of Montgomery County is a private non-profit charitable organization working with public/private partners to provide high-quality, accessible, equitable, efficient, and outcome-driven health care services for low-income, uninsured County residents.

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Montgomery Cares

- A public-private partnership composed of independent safety-net primary care clinics, six hospitals, the Montgomery County Department of Health and Human Services, and the Primary Care Coalition, as well as volunteer health practitioners and other community-based organizations

- Provides and preventive care to low-income individuals (≤ 250% of Federal Poverty Level (FPL) uninsured adults residing in Montgomery County, Maryland. Participating clinics are located throughout the county

- In FY22, 70% of participants reported incomes at or below the FPL. 78% were Hispanic/Latino adults of working age

- Services include medical check-ups, medicine, lab tests, cancer screenings, access to specialists, and other health programs

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Montgomery Cares Behavioral Health Program (MCBHP)

The program began in 2005 in response to the high prevalence of depression and anxiety disorders among Montgomery Cares patients. The program utilizes the Collaborative Care Model created by the AIMS center at the University of Washington.

The MCBHP currently serves patients at 5 organizations with 8 unique sites.

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Startup

- Designed by Montgomery County Department of Health and Human services, PCC, and the Center for Mental Health Outreach in Georgetown University's Department of Psychiatry

- During the first four years of operation the Georgetown University Department of Psychiatry conducted annual program evaluations

- In 2009 the Montgomery County Council approved transitioning the pilot into program status

- In FY2014 and FY2015 the Montgomery County Council approved increases in funding to the program, allowing it to further expand to serve more partner clinic sites

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Payment Model

- Block funding under Montgomery Cares, which is funded by Montgomery County Department of Health and Human Services

- Do not take private insurance or Medicaid/Medicare (patients with these types of coverage are referred to outside providers)

- Do not do Fee-for-Service

Tracking time

- Report to county and other stakeholders on number of times spent on each activity and minutes spent on each activity.

- Services fall into two broad categories. For most of the previous quarters, approximately 1/3 of time has consistently been spent on traditional mental health services such as an initial evaluation or a therapy session and approximately 2/3 of time was spent on collaborative care activities, which includes activities such as case consultation with a psychiatrist and/or a primary care provider, case management, and meeting with a patient to track progress in their treatment.

- Over the past several quarters (generally corresponding with the COVID-19 pandemic), the ratio has been closer to ¼ of time spent on traditional behavioral health and ¾ of time on collaborative care activities.

Behavioral Health Care Manager (**BHCM)** (licensed behavioral health clinician or registered nurse)	• Coordinator for behavioral health • Biopsychosocial Evaluation • Consultation with psychiatrist • On-going Care Management • Short term therapy • Crisis intervention • Case management services/referral to resources • Bilingual in English/Spanish
Community Resource Coordinator	• Intensive case management for patients with complex needs • Home visits, assistance at outside organizations
Psychiatrist	• Provides case consultation to behavioral health staff and primary care providers to support assessment, diagnosis, & treatment. • Provides education to medical providers. • Provides psychiatric treatment for patients who are complex or who do not respond to treatment
Psychiatric Services Coordinator	• Manages program calendar & psychiatry services • Language Interpretation for psychiatrist
Primary Care Provider (PCP)	• Screens and refers patients to behavioral health services • Prescribes medication based on recommendation of consulting psychiatrist

Adaptations of the Collaborative Care Model for the Montgomery Cares population

- Case Management Services and a Community Resource Coordinator
- Direct psychiatric services and a Psychiatric Services Coordinator
- Diagnosis and Treatment of Trauma
- Supervisory Behavioral Health Care Managers
- Bilingual requirement

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Outcomes

MCBHP expanded from one clinic organization with one site and 71 patients receiving services in fiscal year 2006 to five clinic organizations with eight sites and 1,368 unique patients in fiscal year 2022.

Outcomes (continued)

MCBHP collects and shares data related to four quality measures:

1.) Percentage of Primary Care Visits that include a depression screen (goal of 75%)

One of the clinic organizations improved from 51% of visits in FY16 when the measures were first utilized, to 84% in FY23.

2.) Percentage of Active Patients with at least one documented depression screen in the past year (goal of 90%)

One *of the clinic organizations improved from 43% of patients in FY16 when the measures were first utilized, to 92% in FY23.*

3.) Percentage of patients who have a positive depression screen who have a behavioral health visit within 2 months (goal of 50%)

4.) Percentage of patients with clinically significant symptoms of depression with a demonstrated decrease in depression symptoms within six months of initial Behavioral Health evaluation at their most recent score (Goal of 50%)

Challenges

- Provider buy-in
- Maintaining robust, bilingual workforce
- Stigma
- Challenges connecting to outside resources when patient needs exceed scope of MCBHP

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Questions?

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Contact Information

Sarah Frazell sarah_frazell@primarycarecoalition.org

www.primarycarecoalition.org

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Intermountain Health

Collaborative Care at Intermountain Health

MidAtlantic Path Forward Collaborative Care Forum
Friday, July 28, 2023

Mason Turner, MD
BH Senior Medical Director

Janelle Robinson, MBA, MHA
BH Service Line Director

Intermountain Health by the Numbers

7 Primary States[1]
(UT, NV, ID, CO, MT, KS, WY)

60,000+ Caregivers

1,049,000 SelectHealth Members

33 Hospitals
Including 1 Virtual Hospital

$13.9 billion[2]
Total Revenue

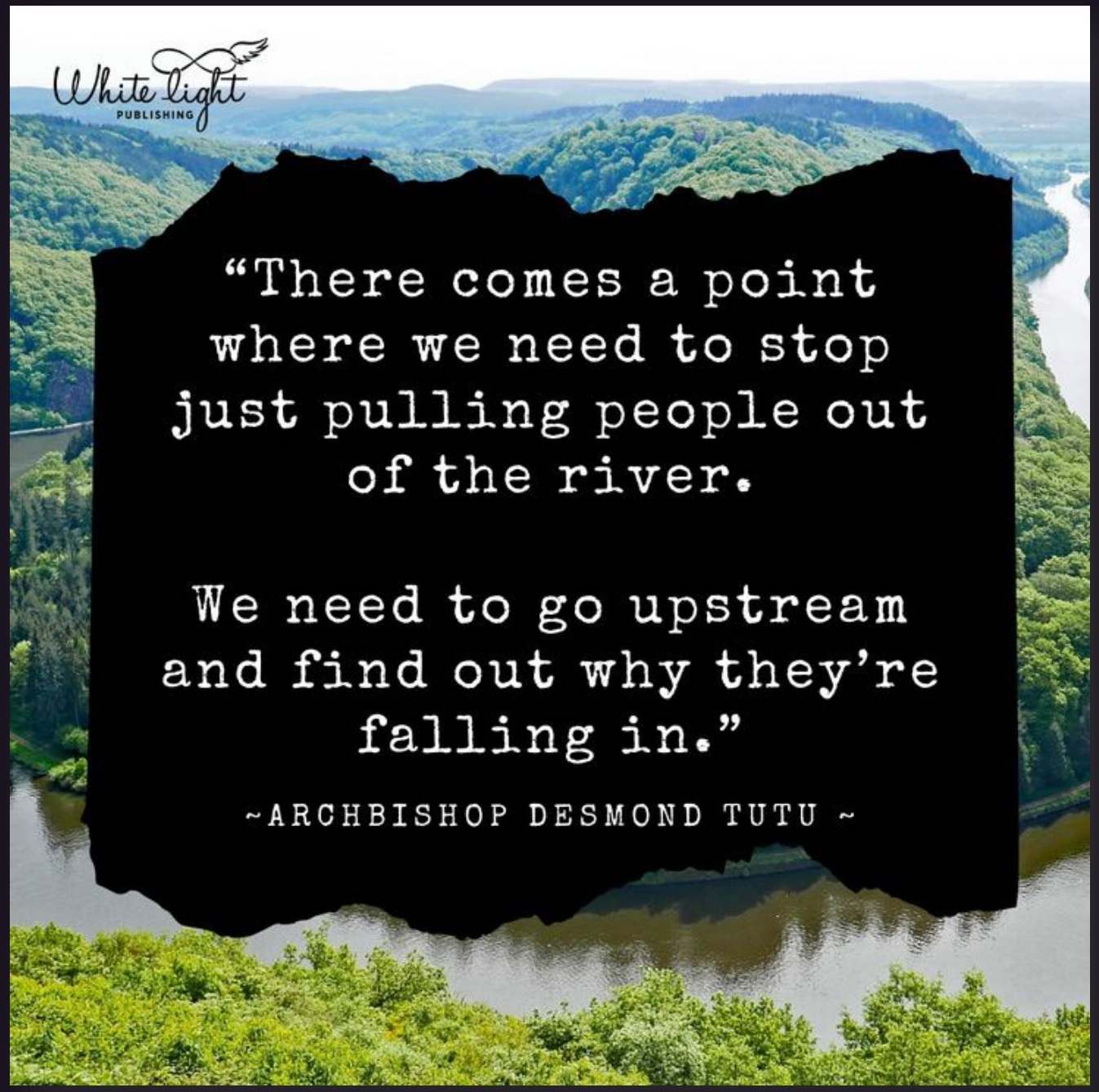
385 Clinics

4,800 Licensed Beds

3,900 Employed Physicians & APPs

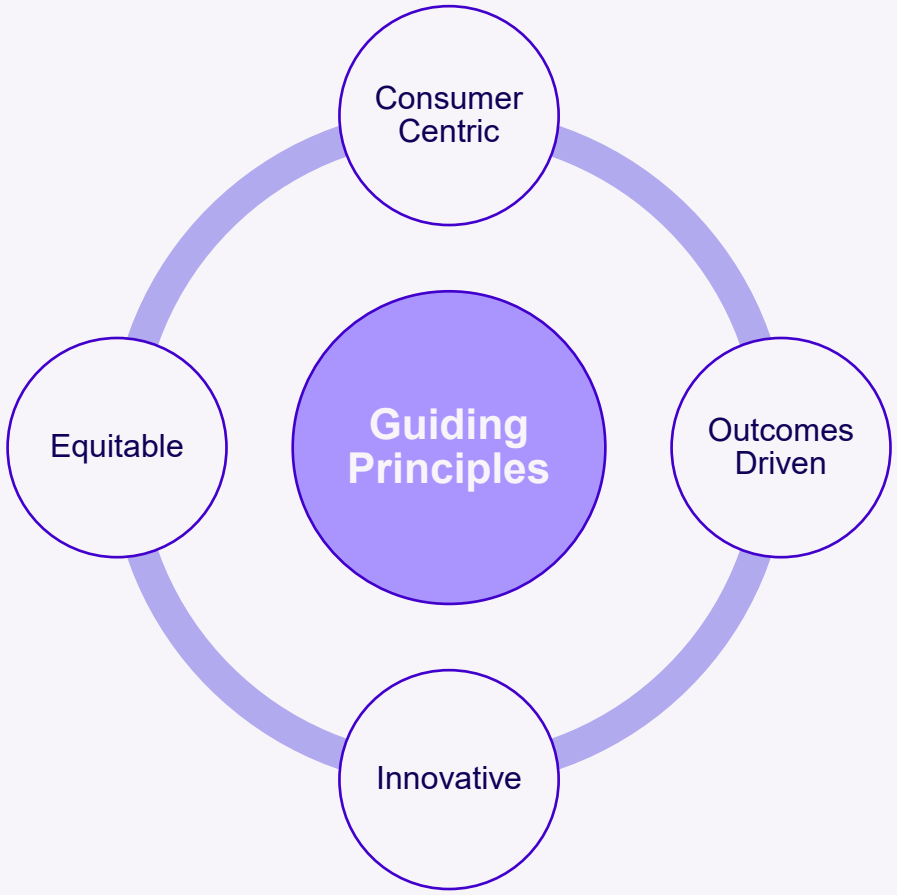
[1] *Intermountain also provides air medical transport services in other states through Classic Air Medical*
[2] *Revenue for the year ended December 31, 2021*

Intermountain Health Organization Strategy


White Light
PUBLISHING
"There comes a point where we need to stop just pulling people out of the river.
We need to go upstream and find out why they're falling in."
~ARCHBISHOP DESMOND TUTU ~

Intermountain Health Behavioral Health

Vision



Core Strategies

1. **Develop Clinical Models of the Future**
   Innovations to create an ecosystem of care
2. **Evolve Current Care Delivery**
   Specialty behavioral health programs to improve mental health
3. **Collaborate with the Community**
   Community partnerships to deliver on core strategies

Intermountain Health

Paradigm Shift

- Suicide rate among the worst in the nation within Intermountain footprint
- Pressure from executive leadership to evolve behavioral health
- New behavioral health leadership team hired in 2021 positioned to make change
- Behavioral health needs post COVID pandemic
- Strategic focus on increasing value to patients in an at-risk payer arrangement
- Strategic funding request approved in 2022 for program start-up costs

Why Intermountain Health Implemented Collaborative Care

Proactive approach to managing mental health

- Patients less likely to fall through the cracks
- Measurable outcomes (PHQ-9/GAD-7 scores are tracked for improvement on a registry)

Patients achieve depression remission faster

- The CoCM model is evidence-based
- 2016 study showed 86 days in CoCM vs. 614 days under usual care

Team-based care allows more attention to the patient and takes some burden off the PCP

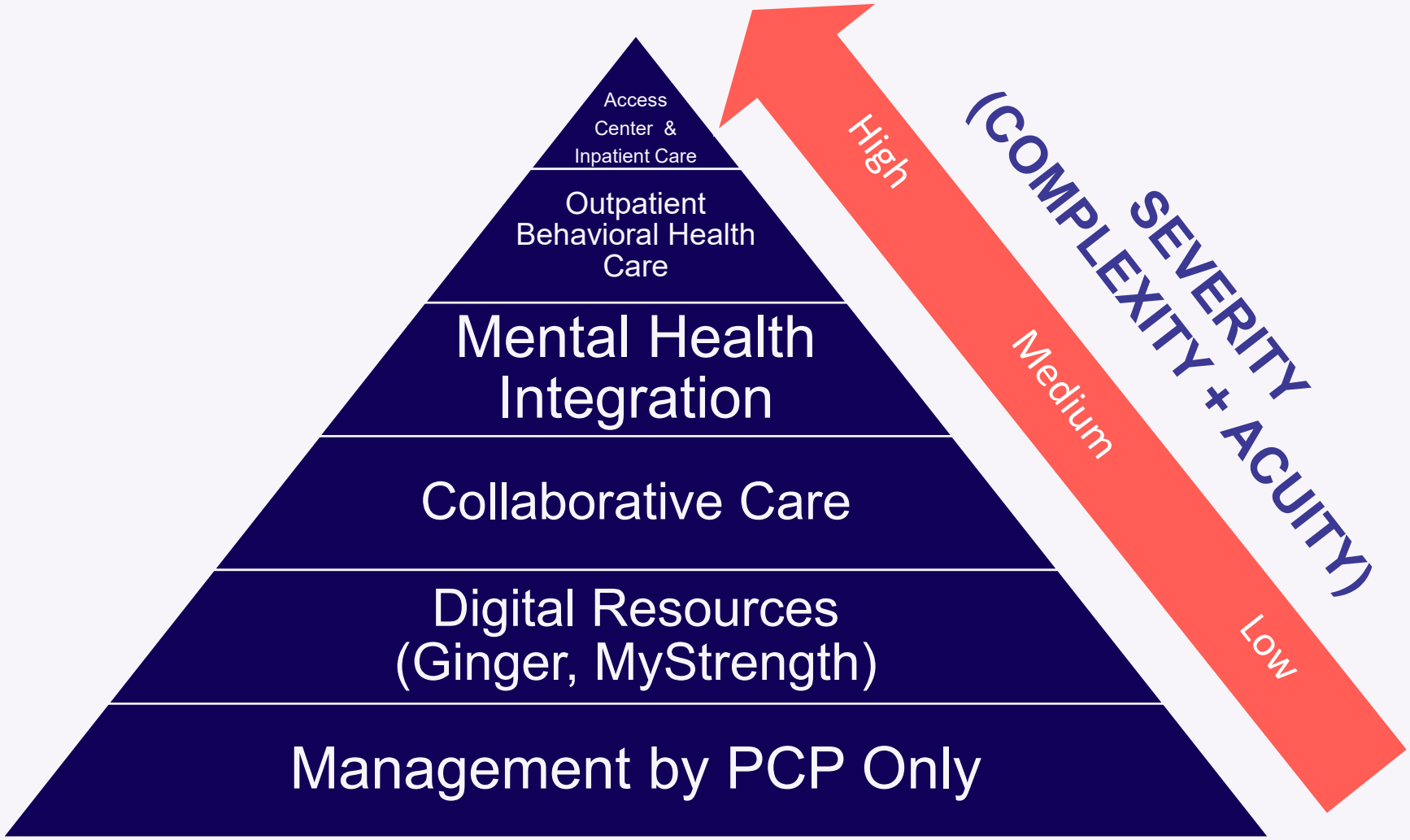
- Time constraints during scheduled visits
- Limited appointment availability for follow up can delay treatment

Limited access to mental health services

- MHI providers with long waitlists
- Patient can receive brief therapy and psychiatric case review all under one umbrella

Garrison GM, Angstman KB, O'Connor SS, Williams MD, Lineberry TW. Time to Remission for Depression with Collaborative Care Management (CCM) in Primary Care. J Am Board Fam Med. 2016 Jan-Feb;29(1):10-7. doi: 10.3122/jabfm.2016.01.150128. PMID: 26769872.

Levels of Behavioral Health Care



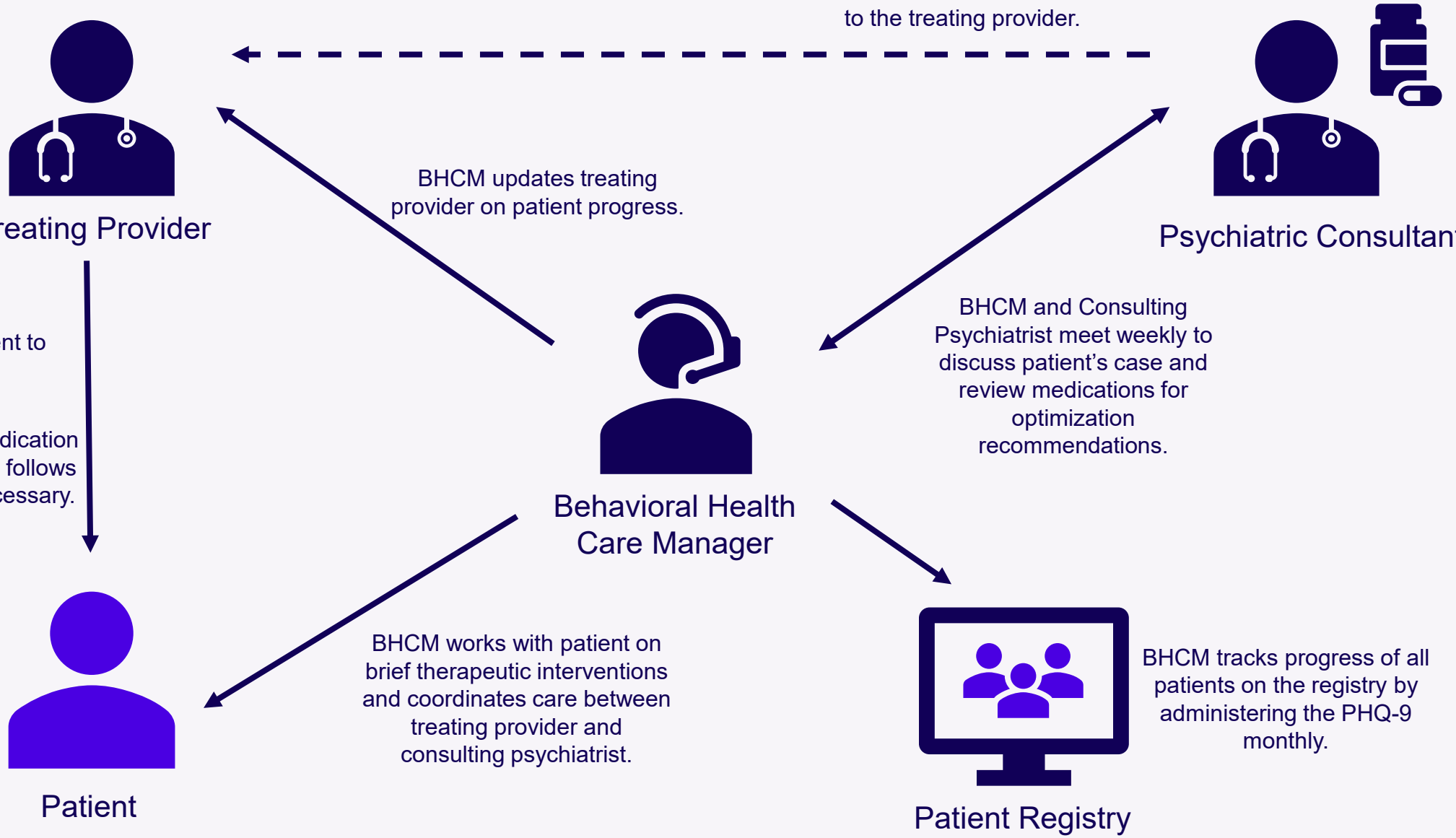
Mental Health Integration

- Short-term, integrated care
- Wider range and higher level of complexity of conditions treated
- Range of contracted insurance plans
- No care management of patients
- Therapy and/or psychiatry services, depending on referral
- Psychiatrist sees patient directly and writes prescriptions
- Traditional therapy sessions scheduled on days the provider is in clinic
- Co-pay per session
- Completion of baseline packet to track outcomes

Collaborative Care

- Short-term, integrated care
- Target population of patients with mild to moderate behavioral health concerns
- At-Risk insurance plans
- Care management component
- Both therapy and psychiatry consultation services for all enrolled patients
- Referring provider manages medications with support from psychiatrist
- Option to schedule virtual/phone appointments throughout the week – more touchpoints
- One monthly co-pay based on time spent with patient
- Registry tracking of patient outcomes

Collaborative Care Team



CoCM Billing

One Monthly Co-Pay

Throughout the month, the behavioral health care manager records the time they spend working with and coordinating care for the patient. This time is added and billed at the end of the month.

RVU Credit to PCP

All CoCM CPT codes are billed under the PCP as the provider receiving RVU credit. Although most of the time spent on CoCM is done by the BHCM and psychiatric consultant, the PCP continues to oversee the patient's care while enrolled in this program.

Multiple Touchpoints

Under a single co-pay, the patient is receiving both therapy and psychiatry support. The BHCM may follow up with the patient multiple times throughout the month, giving them more personalized care. CoCM is a great deal for the patient.

Collaborative Care CPT Billing Codes

Service	CPT Code	Description	RVU for PCP	Expense to Patient
CoCM: Combined Therapy and Psychiatric Consultation	99492	Initial Psych Collaborative Care, First 70 Min	1.88	$239
	99493	Subsequent Psych Collaborative Care, First 60 Min	2.05	$207
	*99494	Initial or subsequent psychiatric collaborative care management / Psych Collaborative Care, Each Addtl 30 Min	0.82	$104
***Medicare will cover up to 145 minutes (3.52 RVU) with add-on code**				

Episode of Care Comparison

Full Treatment RVU/Cost Comparison		
Services	**RVU to PCP**	**Expense to Patient**
3 Months of CoCM + 2 PCP 99214 visits	10.9 3.84	$1,277 $410
TOTAL	**14.74**	**$1,687**
MHI Therapy Eval + 5 60 min follow ups MHI Psychiatry Eval + 2 follow ups + 2 PCP 99214 visits	0 0 3.84	$1,448 $713.50 $410
TOTAL	**3.84**	**$2,571.50**

For 3 months of care under CoCM (the average amount of time to depression remission under this model), the cost would be significantly less than receiving both therapy and psychiatry through MHI.

Additionally, the PCP receives full RVU credit for the care the patient receives under this model.

MHI vs. CoCM Patient Cost Comparison

MHI Expense to Patient			CoCM Expense to Patient		
Services	**Time Spent**	**Cost**	**Services**	**Time Spent**	**Cost**
MHI Psychiatry Evaluation	60 minutes	$303.50	**CoCM Psych Consult & Therapy**	*145 minutes (variable)	$447
MHI Therapy Evaluation	60 minutes	$273			
TOTAL	120 minutes	$576.50	**TOTAL**	145 minutes	$447

For a new patient to receive both psychiatry and psychotherapy treatment through MHI, the cost is higher for less time than a patient would receive during one month in CoCM.

Which Patients Qualify for Intermountain's CoCM?

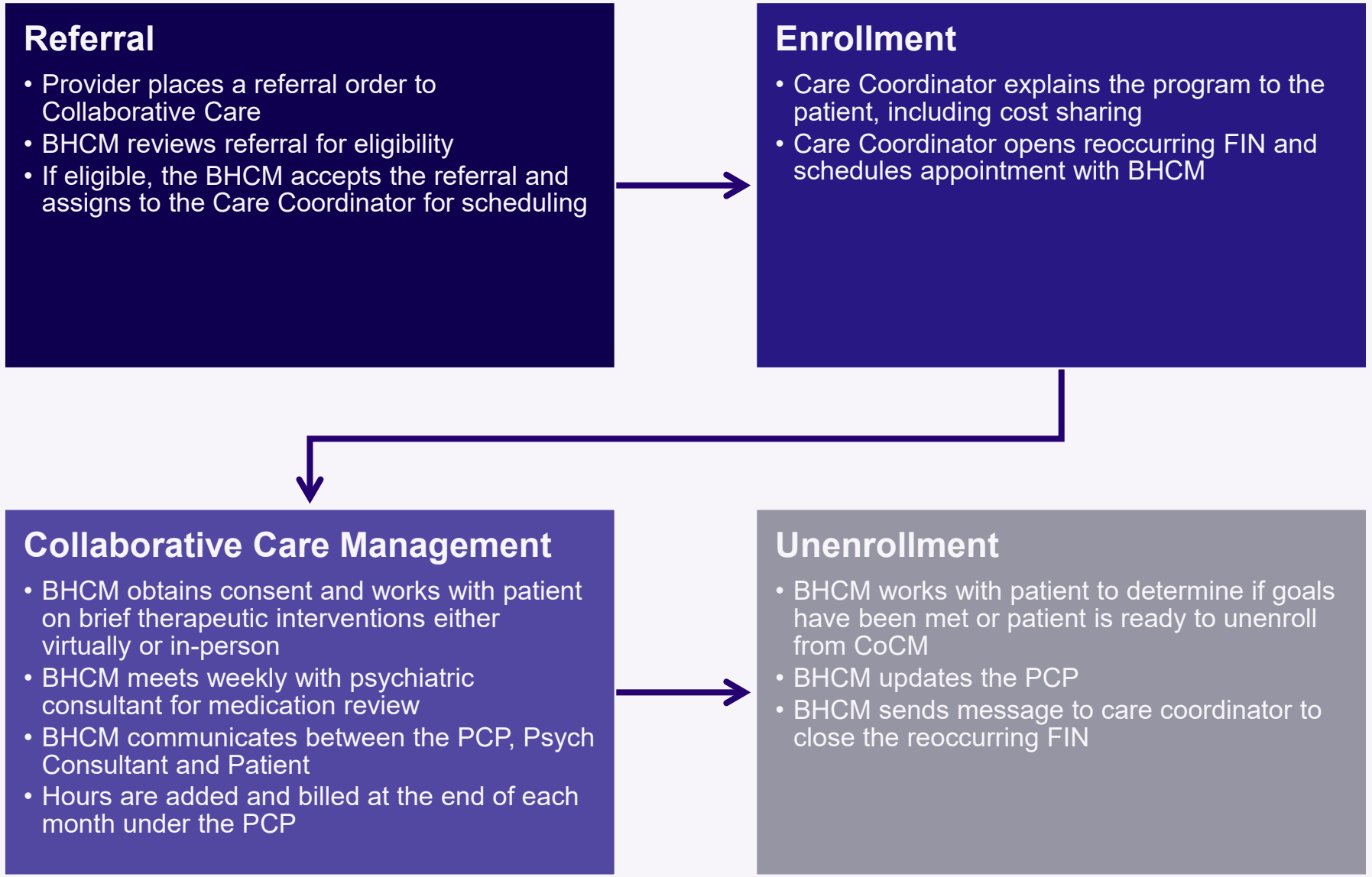
Inclusion Criteria

- Adult patients (18+)
- At-risk payer
- PHQ-9 and/or GAD-7 ≥ 10
- Clinical determination – PCP can refer any patients they think could benefit and the Care Manager will review

Exclusion Criteria

- <18 years old
- High complexity (schizophrenia, confirmed bipolar depression, dementia)
- Currently receiving psychiatric medication management from a psychiatric provider (okay to be currently in therapy only)
- Have not been seen by PCP within the last year
- Non-At-Risk insurance plan

CoCM Process (Referral Order)



Patient Registry

- Cerner is our electronic medical record
- We built the registry in Tableau, pulling in data from our data warehouse to create the registry

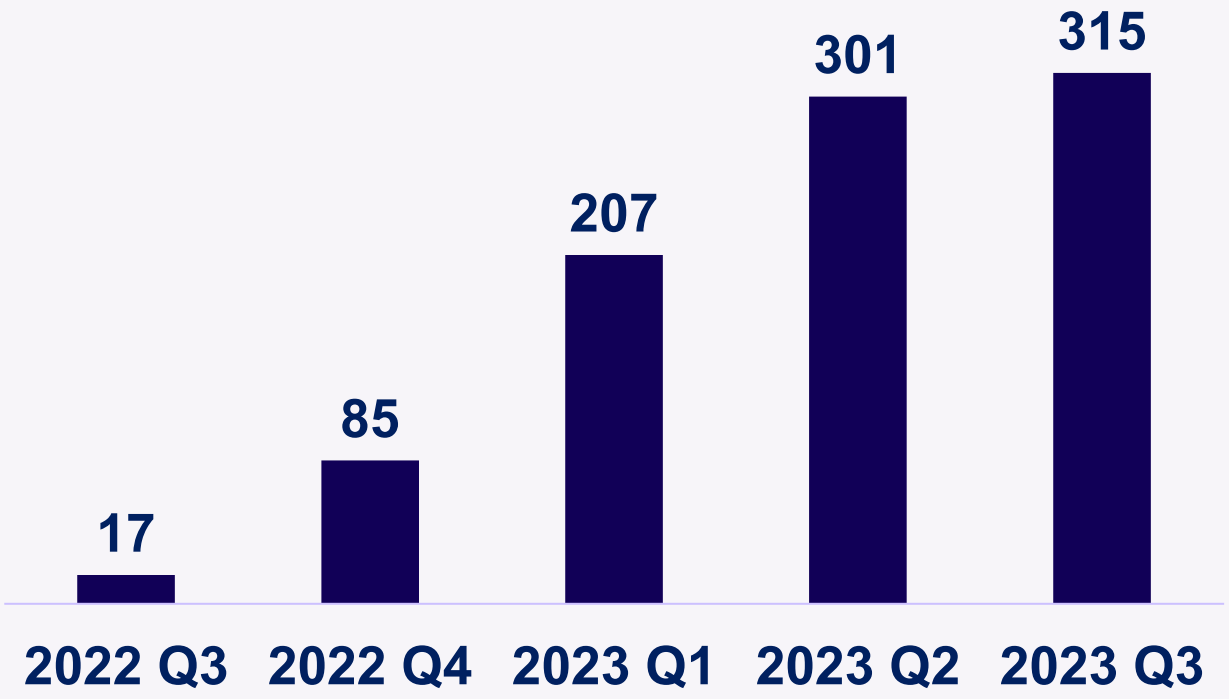
Case Overview

Welcome [redacted]

Last Updated: 4/10/2023 4:34:30 AM

Patient ID	Treatment Status	Patient Name	Enrollment	Total Previous Month Contact Duration	Total Contact Duration	Last Contact	Average # Contacts per Month	# Followups	Weeks in Treatment	Last Psychiatric Review	Initial PHQ Score	Last PHQ Score	Last PHQ Date	PHQ Change	Initial GAD7 Score	Last GAD7 Score	Last GAD7 Date	GAD7 Change
[redacted]	Active	[redacted]	09/21/2022	45	2	04/06/2023	2.4	16	29	03/27/2023	11	2	04/06/2023	82%	10	4	02/28/2023	60%
[redacted]	Active	[redacted]	09/29/2022	89	0	03/24/2023	2.1	14	28	02/03/2023	13	6	04/05/2023	54%	10	14	02/22/2023	-40%
[redacted]	Active	[redacted]	10/11/2022	117	28	04/06/2023	3.0	20	26	02/23/2023	14	14	03/29/2023	0%	20	20	01/13/2023	0%
[redacted]	Active	[redacted]	10/18/2022	30	0	03/09/2023	2.2	12	25	02/10/2023	14	11	03/09/2023	21%		4	03/09/2023	
[redacted]	Active	[redacted]	10/11/2022	129	40	04/07/2023	3.1	21	26	03/27/2023	12	3	04/07/2023	75%		3	04/07/2023	
[redacted]	Active	[redacted]	10/17/2022	118	53	04/04/2023	3.8	22	25	03/27/2023	10	13	04/04/2023	-30%	10	10	03/07/2023	0%
[redacted]	Active	[redacted]	10/19/2022	50	0	03/21/2023	3.2	18	25	03/20/2023	21	10	03/07/2023	52%	14	5	03/21/2023	64%
[redacted]	Active	[redacted]	10/25/2022	260	60	04/07/2023	4.0	23	24	03/09/2023	16	18	03/27/2023	-13%		8	12/27/2022	
[redacted]	Active	[redacted]	10/31/2022	87	30	04/07/2023	3.5	20	23	03/09/2023	14	4	04/06/2023	71%	11	15	02/01/2023	-36%

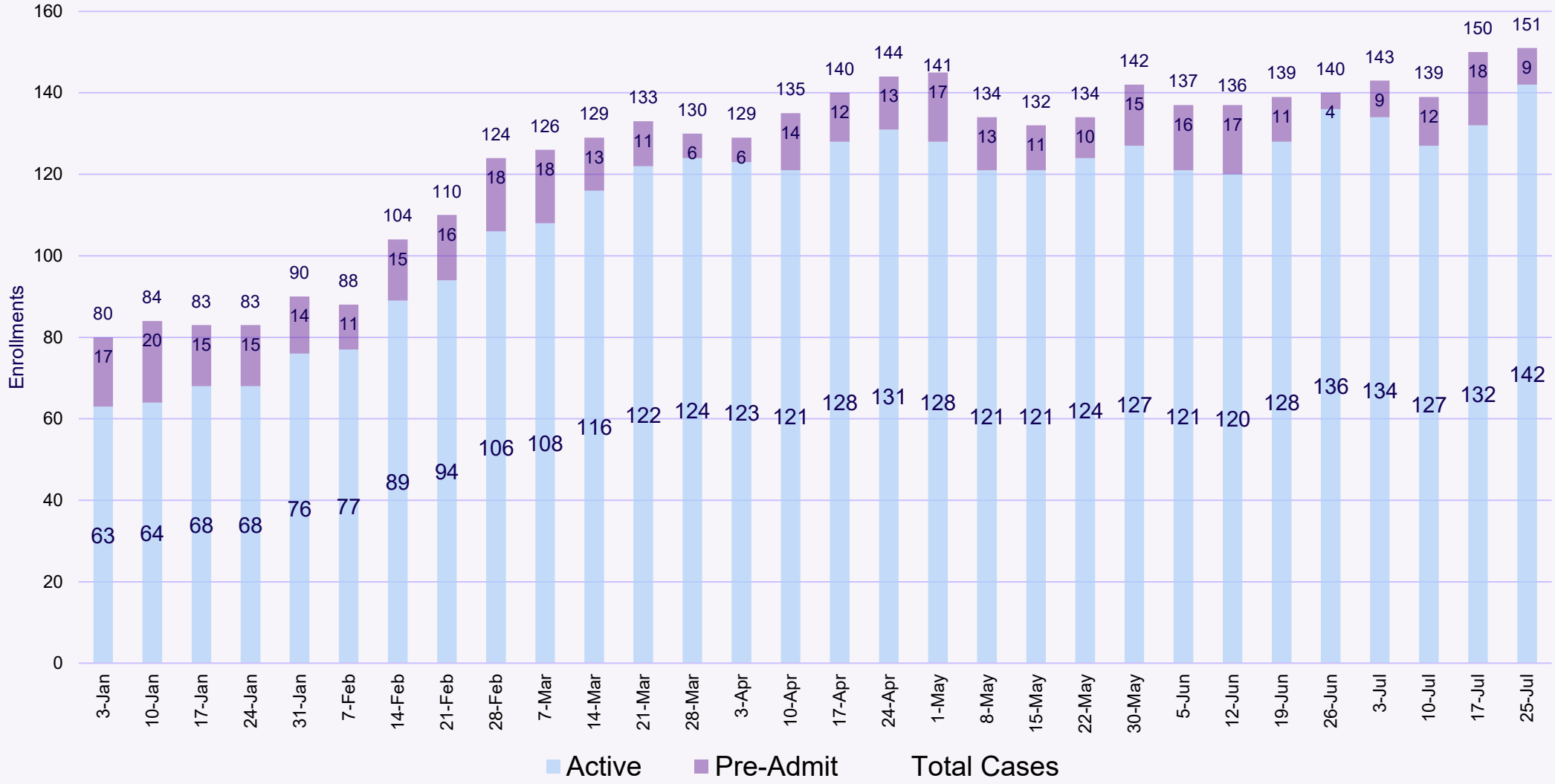
CoCM Quarterly Enrollment Growth



Phases of Implementation

Registry Growth KPI Goals (Active Cases)	
Entry	200
Target	250
Stretch	300

2023 CoCM Total Weekly Enrollments



Preliminary Collaborative Care Outcomes

Total Collaborative Care Patients
312
137 Active, 175 Discharged

24% of patients reached remission

Average reductions in scores:

PHQ-9: **34.7%**
GAD-7: **17.7%**

Patients enrolled in the program for
98 days
on average

Percent of Patients with >50% reduction in scores:

PHQ-9: **36.0%**
GAD-7: **12.1%**

Patients reached remission in
138 days
on average

Data updated 7/25/2023

Collaborative Care Expansion Plans

- Endocrinology launch this month
- Additional primary care clinics
- Additional women’s health clinics
- Pediatric pilot workgroup
- CoCM dashboard is in development

Challenges

- Change management
- Clinics with other MH Services embedded struggle to adopt
- Care Manager turnover
- Local clinic engagement
- Identifying and engaging all levels of stakeholders throughout complex system

Lessons Learned

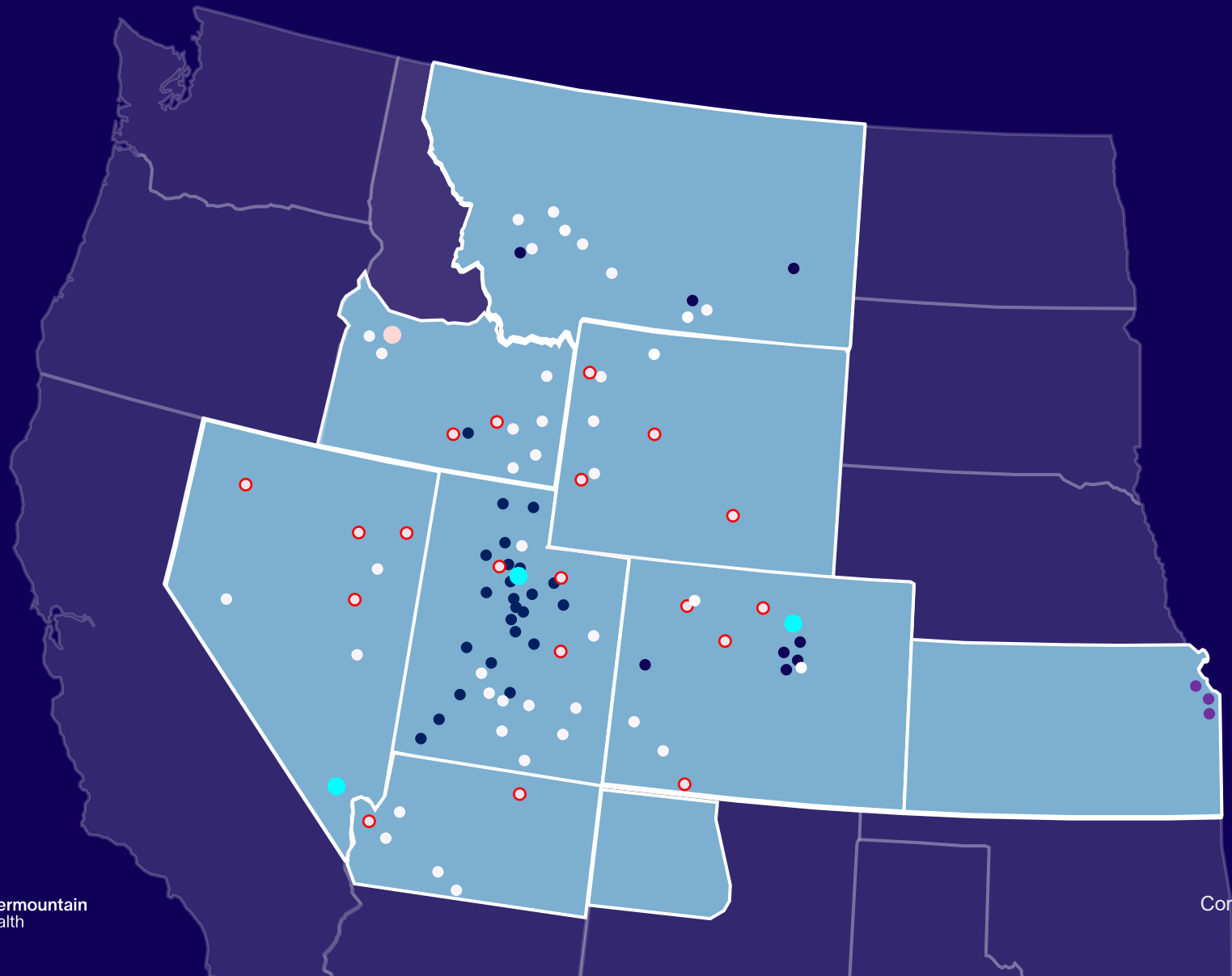
- Importance of expert consultant
- Start with clinics without any existing MH support
- Must have the right fit for Care Manager
- Value of dedicated operations coordinator
- PCP champion at each clinic
- Importance of case finding through universal screening at each clinic

Questions?

Appendix

Intermountain Health

Intermountain Health's Current Footprint



- Hospitals
- Region HQ
- Saltzer Health
- Affiliate/Outreach Partnerships
- Classic Air Medical Bases
- Kansas community clinics

Behavioral Health System Leadership

Janelle Robinson, MBA/MHA
Service Line Director
Medical Group

Gena Christensen, MSN, RN
Nurse Director
Community Services

Mason Turner, MD
Senior Medical Director
Behavioral Health

Tammer Attallah, LCSW, MBA
Executive Director
Behavioral Health Clinical Program

Shelly Read, RN, MSN
Executive Director
Clinical Ops Acute Care

Medical Group
Behavioral Health Service Line

- Oversite of Medical Group clinics
- Provider staffing & recruitment with markets
- Engagement with providers
- Ambulatory Strategy
- Advisor for BH MG Operations
- Provider performance

Clinical Program
Behavioral Health Clinical Program

- Consultative & advisory role
- Affiliated providers
- System Strategy
- Care Process Models & Best Practice Standards
- Coordination in growth markets
- Clinical Models of the Future

Inpatient, Access Center & Crisis Operations
Acute Care

- Provider staffing
- Protocols
- Clinical workflows
- Equipment
- Hospital-related issues

Behavioral Health Clinical Leaders

Ben Holt, MD
Associate Medical Director
Inpatient Behavioral Health

Wei-Li Hsu, DO
Associate Medical Director
Outpatient Behavioral Health

Robert Mendenhall, DO
Associate Medical Director
Dayspring | Substance Use

David Burrow, MD
Associate Medical Director
Mental Health Integration

Saphu Pradhan, MD
Associate Medical Director
Primary Care/Mental Health Integration

Denise Lash, PhD
BH Therapy Director
Behavioral Health

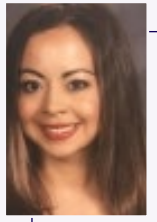
Cathie Fox, PhD
BH Therapy Director
Behavioral Health

Wendy Johnson, PMHNP-BC
APP Director
Behavioral Health

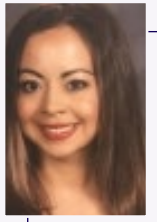
Intermountain Health

Collaborative Care Clinics

Behavioral Health Care Managers



IMC Nurse Midwives
Jesenia Rivera-Perez, LCSW



Rose Canyon Family Medicine
Jesenia Rivera-Perez, LCSW

Sunset Family Medicine
Ryan Budge, LCSW

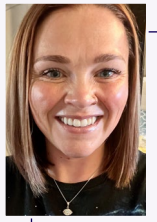
Lehi Family Medicine
Kristina Cheney, LCSW

Spanish Fork Family Medicine
Kristina Cheney, LCSW

Utah Valley FM, IM, Senior Medicine
Sarah Campbell, CSW

West Jordan Family Medicine
Leah Kitzmiller, CSW

West Valley Family Medicine
Kayla Duncan, CSW



Endocrinology Clinics
Jessica Curtis, LCSW

Collaborative Care Psychiatric Consultants

Dr. David Burrow

Lehi FM, Rose Canyon FM, Spanish Fork FM, Sunset FM, Utah Valley FM/IM/Senior

Dr. Brittany McColgan

IMC Nurse Midwives, West Jordan FM, West Valley FM

Collaborative Care Model (CoCM)

- An evidence-based model where patients with lower complexity mental health needs can receive mental health care, integrated within their existing medical provider's clinic.
- Team-based care:
  - Treating provider
  - Behavioral Health Care Manager
  - Psychiatric Consultant
- Patients are tracked in a registry, using measurable outcomes (PHQ-9/GAD-7) and treated to target, using brief therapeutic interventions and medication optimization
- One monthly co-pay is billed based on time spent with the patient. This is billed under the treating provider who is receiving all RVU credit for overseeing the patient's care while enrolled.
  - Patients may have multiple touchpoints throughout the month under this single co-pay. The Behavioral Health Care Manager can meet with the patient virtually or in-clinic.

Billing Requirements

Eligible Condition

Any mental, behavioral health, or psychiatric condition treated by the PCP, including substance use disorders, that, in the clinical judgment of PCP, calls for collaborative care services.

Initiating Visit

Medicare requires an initiating visit for new patients or patients not seen within 1 year prior to starting collaborative care. This visit establishes the patient's relationship with the PCP and ensures they are assessed prior to starting treatment.

Advance Consent

The patient must give the PCP permission to consult with relevant specialists, which includes talking with a psychiatric consultant. The CoCM team must inform the patient that cost sharing applies. You may get verbal consent from the patient (Medicare doesn't require written consent) but you must document it in the medical record.

Psychiatric Note Example

CoCM Psychiatric Consultant Recommendations

Collaborative Care Consultation

Patient Name: Doe, Jane
Referring Provider: Jones, MD, Andrea
Most Recent Collaborative Care Review: March 7, 2023

Recommendations:
1. Medication Recommendations:
-Consider cross-tapering fluoxetine (currently 40mg daily) to sertraline (target dose 100mg daily):
--Decrease fluoxetine to 20mg by mouth daily and start sertraline 50mg daily, continue for one week, then
--Stop fluoxetine and increase sertraline to 100mg daily.
--Continue sertraline (if tolerated) for a minimum of 2 weeks, up to 4 weeks before considering further dose adjustment.

Fluoxetine is a capsule (the tablets are not well-covered by insurance), so I would recommend providing a prescription for 7x20mg capsules for the cross taper.

Sertraline is a tablet. I would recommend providing a prescription for 30x100mg tablets, with instructions to cut the tablets in half for the first week, then increase to a full tablet when fluoxetine is stopped.

Information relevant to informed consent
The risk of serotonin syndrome is incredibly low. It's an infrequent (but serious) adverse reaction, even when on a high-risk combination. This is not a high-risk combination and will help to minimize the risk of withdrawal symptoms.

Common withdrawal symptoms include dizziness, light-headedness, malaise, achiness, headache, and a shock-like sensation usually felt in the head and sometimes radiating to the shoulders and arms. All are unpleasant and time limited, none signify and significant health risk.

Serotonin syndrome symptoms to watch for include fever, confusion, agitation, abdominal or other large muscle spasms, severe diarrhea, and hyperreflexia. Patient should be instructed to stop the medication and seek immediate examination through an urgent care of ED if multiple of these symptoms begin at once.

Common adverse effects of SSRIs such as fluoxetine and sertraline include nausea, more mild diarrhea, headaches, tinnitus, sedation (sertraline), sleep disturbance (fluoxetine), and approximately 20% of people taking a reuptake inhibitor antidepressant experiences changes in sexual function (most commonly decreased interest in sex, prolonged time to orgasm, or erectile dysfunction). Most adverse effects other than sexual dysfunction will resolve within 1-2 weeks of starting treatment. Sexual dysfunction, when bothersome, usually requires a change to medication to resolve.

2. Therapy Recommendations:
-Continue current CoCM brief interventions (Collaborative Care Specialist)
-Consider referral for Cognitive Behavioral Therapy for Insomnia (CBT-I).

3. Further Investigation:
-Collaborative Care Specialist to use the CIDI Bipolar Disorder Screening instrument to further evaluate for bipolar disorder, but based on current information I think this is not a likely diagnosis.

Diagnoses/Reasoning:
1. **Major depressive disorder, recurrent, moderate, in partial remission**: Symptoms of depression are currently mild. Pattern of symptoms in the past has raised some questions about bipolar disorder, but history as described to the CCS does not sound like she has a history of manic or hypomanic episodes. Not feeling like fluoxetine has helped at all, but this has been her only medication trial. Switching to sertraline may be reasonable, it has good evidence for Major Depressive Disorder, Generalized Anxiety Disorder. Patient is currently hypertensive, and SNRIs and bupropion may be more prone to worsening hypertension, so would not recommend those yet.

2. **Generalized anxiety disorder**: Describes a history of general, near-constant worrying about many things at once to such a degree that she gets physically worn out, irritable, restless, and has difficulty concentrating. She gets tense and sore when the anxiety is worse. Sertraline is a good candidate for treating Generalized Anxiety Disorder.

Closing Remarks

Next Session: August 25, 2023

12:00 – 1:00 pm

Thank you!