CARE COMPASS NETWORK

Title: Integrated Behavioral Health and Primary Care – Approved Primary Care Screens
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Purpose: The purpose of this guideline is to establish a menu of approved primary care screenings for use in the 3ai Integration of Behavioral Health and Primary Care (Model 2) project. Participating behavioral health sites may choose from the menu of approved screenings.

See attachment for list of screenings.

Clinical Guideline Board Approval History: 12/08/2015

Clinical Guideline Revisions:

Date	Revision Log	Updated By
11/30/2015	Initial Draft	E. Pape

This Clinical Guideline shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network's senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations.

CARE COMPASS NETWORK

Preventive Care Screening Recommendations

Care Compass Network (CCN) project leaders for Project 3ai Integrating Behavioral Health and Primary Care (Model 2), in collaboration with the CCN Clinical Governance Committee, and the Behavioral Health Quality Committee recommend the following preventive care tests and screening tools. These tools and tests are recommended because of their value in addressing or identifying common physical health ailments that coexist with behavioral health illnesses, or that result from prolonged use of psychiatric medications. These recommendations are evidence based and are consistent with practice guidelines put forth by the American Psychiatric Association (Third Edition; 2016).

1. **Screen for Metabolic Syndrome**—risk factors which raise a patient's risk for heart disease, diabetes, and stroke.

   The American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinology, and North American Association for the Study of Obesity issued a consensus statement recommending on-going monitoring of metabolic syndrome risk factors. Specifically, the consensus statement says:

   > Clinicians who prescribe SGAs [second generation antipsychotics] for patients with psychiatric illnesses should have the capability of determining a patient's height and weight (BMI) and waist circumference. These values should be recorded and tracked for the duration of treatment. Clinicians should also encourage patients to monitor and chart their own weight. It is particularly important to monitor any alteration in weight following a medication change. The patients' psychiatric illness should not discourage clinicians from addressing the metabolic complications for which these patients are at increased risk.

Monitoring protocol for patients on Second Generation Antipsychotic Medications						
	Baseline	4 weeks	8 weeks	12 weeks	Annually	Every 5 Years
Personal/ Family History	X				X	
Weight (BMI)	X	X	X	X		
Waist Circumference	X				X	
Blood Pressure	X			X	X	
Fasting Plasma Glucose	X			X	X	
Fasting Lipid Profile	X			X		X

REFERENCE: "Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes" American Diabetes Association, American Association of Clinical Endocrinology, and North American Association for the Study of Obesity. *Diabetes Care* (v27, No. 2) February 2004.

In addition, the following tests are recommended for identifying risk for metabolic syndrome:

- Hemoglobin A1C
- TSH Screening for Thyroid Function and Disease

2. **Screen for Hepatitis C**

The US Preventive Services Task Force (USPSTF) recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering a one-time screening for HCV infection to adults born between 1945 and 1965.

The most important risk factor for HCV infection is past or current injection drug use. Another established risk factor for HCV infection is receipt of a blood transfusion before 1992. Because of the implementation of screening programs for donated blood, blood transfusions are no longer an important source of HCV infection. In contrast, 60% of new HCV infections occur in persons who report injection drug use within the past 6 months.

Tests: Hepatitis C can be detected using a HCV antibody test following by confirmatory PCR.

REFERENCE: "Screening for Hepatitis C Virus Infection in Adults: A Systematic Review for the U.S. Preventive Services Task Force" *Annals of Internal Medicine* 2013; 158: 101-108.

3. **Screen for Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome**

The US Preventive Services Task Force (USPSTF) recommends screening for HIV/AIDS for all pregnant women, including those who present in labor who are untested and whose HIV status is unknown.

The US Preventive Services Task Force (USPSTF) recommends that clinicians screen for HIV infection in adolescents and adults aged 15-65 years. Younger adolescents and older adults who are at increased risk should also be screened.

From the USPSTF recommendation:

> On the basis of HIV prevalence data, the USPSTF considers men who have sex with men and active injection drug users to be at very high risk for new HIV infection. Behavioral risk factors for HIV infection include having unprotected vaginal or anal intercourse; having sexual partners who are HIV-infected, bisexual, or injection drug users; or exchanging sex for drugs or money. Other persons at high risk include those who have acquired or request testing for other sexually transmitted infections (STIs). Patients may request HIV testing in the absence of reported risk factors. Individuals not at increased risk for HIV infection include persons who are not sexually active, those who are sexually active in exclusive monogamous relationships with uninfected partners, and those who do not fall into any of the aforementioned categories. The USPSTF recognizes that these categories are not mutually exclusive, the degree of sexual risk is on a continuum, and

individuals may not be aware of their sexual partners' risk factors for HIV infection. For patients younger than 15 years and older than 65 years, it would be reasonable for clinicians to consider HIV risk factors among individual patients, especially those with new sexual partners. However, clinicians should bear in mind that adolescent and adult patients may be reluctant to disclose having HIV risk factors, even when asked.

Tests: HIV can be detected using any of the following tests

- The conventional serum test for diagnosing HIV infection is repeatedly reactive immunoassay, followed by confirmatory Western blot or immunofluorescent assay. Conventional HIV test results are available within 1 to 2 days from most commercial laboratories.
- Rapid HIV testing may use either blood or oral fluid specimens and can provide results in 5 to 40 minutes; however, initial positive results require confirmation with conventional methods.
- Other U.S. Food and Drug Administration–approved tests for detection and confirmation of HIV infection include combination tests (for p24 antigen and HIV antibodies) and qualitative HIV-1 RNA.

REFERENCE: Chou R, Selph S, Dana T, Bougatsos C, Zakher B, Blazina I, Korthuis PT. Screening for HIV: Systematic Review to Update the U.S. Preventive Services Task Force Recommendation. Evidence Synthesis No. 95. AHRQ Publication No. 12-05173-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; November 2012.

4. Regularly measure patient vitals.
    - Pulse rate
    - Body temperature
    - Respiration rate
    - Blood pressure

5. Screen for **Chronic Obstructive Pulmonary Disease** (COPD). Care Compass Network recommends screening for COPD, as it aligns with other population health needs identified in our community.

    Tests: COPD can be detected using the following tests

    - Pulmonary function tests, including spirometry, measurement of lung volumes, diffusing capacity, and pulse oximetry.
    - Chest X-ray
    - CT scan
    - Arterial blood gas analysis.

6. Complete a **Pain Assessment**

   Chronic pain can have physiological, social, and psychological dimensions that can harm health, functioning, and well being. Chronic pain can be difficult to assess and treat given its multidimensional nature, with objective and subjective aspects. Chronic pain can underpin mental health issues and substance abuse disorders.

   For example, Care Compass Network suggests the following pain assessment tools:

   - Brief Pain Inventory (Short Form)
   - McGill Short Form Pain Inventory

   REFERENCE: Substance Abuse and Mental Health Services Administration. Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. Treatment Improvement Protocol (TIP) Series 54. HHS Publication No. (SMA) 12-4671. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

7. Complete a complete assessment of a patient's current medications and medical history, including past injuries and current medical treatment.

   The American Psychiatric Association recommends assessing patients' current general medical status, current medications, and general medical history. Current medications includes all prescription, non-prescription, herbal and nutritional supplements, and vitamins.

   For example, Care Compass Network suggests the following assessment tool:

   - Physical Health Inventory CT Version 04-2012

   REFERENCE: The American Psychiatric Association practice guidelines for the psychiatric evaluation of adults / APA Work Group on Psychiatric Evaluation, Joel J. Silverman, chair, [and eleven others]. — Third edition. p. ; cm. (Accessed November 21, 2015; available online: http://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426760)

The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults

THIRD EDITION

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The authors have worked to ensure that all information in this book concerning drug dosages, schedules, and routes of administration is accurate as of the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice advance, however, therapeutic standards may change. For this reason and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of a physician who is directly involved in their care or the care of a member of their family.

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ing questioning relating to key elements of the cultural identity of the individual, cultural conceptualizations of distress, psychosocial stressors and cultural features of vulnerability and resilience, and cultural features of the relationship between the individual and the clinician. Depending on the patient's answers to initial questions in the interview, supplementary modules are available to guide detailed questioning.

GUIDELINE VI. Assessment of Medical Health

Guideline Statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of whether or not the patient has an ongoing relationship with a primary care health professional.

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- General appearance and nutritional status
- Involuntary movements or abnormalities of motor tone
- Coordination and gait
- Speech, including fluency and articulation
- Sight and hearing
- Physical trauma, including head injuries
- Past or current medical illnesses and related hospitalizations
- Relevant past or current treatments, including surgeries, other procedures, or complementary and alternative medical treatments
- Allergies or drug sensitivities
- Sexual and reproductive history
- Past or current sleep abnormalities, including sleep apnea

Statement 3. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of all medications the patient is currently or recently taking (i.e., both prescribed and nonprescribed medications, herbal and nutritional supplements, and vitamins) and the side effects of these medications.

Statement 4. APA suggests (2C) that the initial psychiatric evaluation of a patient also include assessment of the following:

- Height, weight, and body mass index (BMI)
- Vital signs
- Skin, including any stigmata of trauma, self-injury, or drug use
- Cardiopulmonary status
- Past or current endocrinological disease
- Past or current infectious disease, including sexually transmitted diseases, HIV, tuberculosis, hepatitis C, and locally endemic infectious diseases such as Lyme disease
- Past or current neurological or neurocognitive disorders or symptoms
- Past or current symptoms or conditions associated with significant pain and discomfort

Statement 5. In addition to a psychiatric review of systems,[4] APA suggests (2C) that the initial psychiatric evaluation of a patient include a review of the following systems:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes

[4] As recommended in "Guideline I: Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History."

- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Endocrine
- Hematological/lymphatic
- Allergic/immunological

Rationale

The goal of this guideline is to improve, during an initial psychiatric evaluation, identification of nonpsychiatric medical conditions that could affect the accuracy of a psychiatric diagnosis and the safety of a psychiatric treatment plan.

The strength of research evidence supporting statements 1, 2, and 3 is low. As described under "Review of Supporting Research Evidence," studies were identified that do address whether diagnostic accuracy is improved by physical assessment or a medical history, but these elements of the evaluative process were not examined as discrete interventions. The studies also did not address whether treatment safety is affected by physical assessment, medical history, review of medications, or review of systems, or whether diagnostic accuracy is affected by review of medications or review of systems. The lack of generalizability of these studies is an additional factor that weakens their strength. Despite this, there is consensus by experts that including the assessments described in statements 1, 2, and 3 in an initial psychiatric evaluation has benefits for diagnostic accuracy and treatment safety that clearly outweigh the potential harms.

Individuals with psychiatric disorders can have medical conditions that influence their functioning, quality of life, and life span. Relative to the general population, mortality rates are increased for individuals with mental illness, particularly those with psychotic disorders, depressive disorders, alcohol/substance use disorders, personality disorders, and delirium (Chang et al. 2010; Chwastiak et al. 2010; Fok et al. 2012; Haklai et al. 2011; Honkonen et al. 2008; Høye et al. 2013; Lemogne et al. 2013; Markkula et al. 2012; Witlox et al. 2010). Estimates suggest that the life span of an individual with a mental illness is approximately 8 years shorter than the life span of individuals in the general population (Druss et al. 2011). For individuals with serious mental illness, the reduction is even more dramatic: up to 25 years (Parks et al. 2006; Saha et al. 2007). Individuals with mental illness have increased cardiovascular mortality (Miller et al. 2006; Morden et al. 2012; Newcomer and Hennekens 2007; Osborn et al. 2007; Parks et al. 2006; Piatt et al. 2010; Roshanaei-Moghaddam and Katon 2009), greater incidence of medical conditions (Dickerson et al. 2006a; Kisely et al. 2008; Leucht et al. 2007; McGinty et al. 2012; Osborn et al. 2007), greater risk of injury (McGinty et al. 2013; Piatt et al. 2010), and greater rates of health risk factors such as obesity and tobacco use (Dickerson et al. 2006b; Lawrence et al. 2009; Osborn et al. 2006). Dental health is also poorer in those with severe mental illness (Kisely et al. 2011; Leucht et al. 2007) and can contribute to health risks such as community acquired pneumonia and endocarditis. Physical functioning is often reduced as well (Chafetz et al. 2006) and may be independently associated with mortality risk (Hayes et al. 2012). When individuals with a serious mental illness are diagnosed with medical conditions, they may be less aware of their concomitant disorders than individuals without a mental illness (Kilbourne et al. 2006). In addition, the quality and type of treatment they receive is frequently disparate from care received by the general population (Druss et al. 2011; Goldberg et al. 2007; Kilbourne et al. 2008; Kisely et al. 2011; Mitchell et al. 2009, 2012; Salsberry et al. 2005). Furthermore, some individuals with mental illness may be unable to understand and adhere to treatment for their illness.

These disparities in care for those with psychiatric illness worsen the morbidity and mortality due to medical conditions as compared with individuals in the general population.

Psychiatric and medical issues are interrelated in a number of other ways. Medical conditions can contribute to the genesis of psychiatric symptoms and syndromes (American Psychiatric Association 2013b; David et al. 2009) or can complicate the diagnosis of psychiatric disorders. For example, an individual with hyperthyroidism may develop symptoms of anxiety. A frontal lobe tumor may result in a mood syndrome or neurocognitive impairment. An individual with uremia or obstructive sleep apnea may feel apathetic, fatigued, and inattentive, wrongly implying the presence of depression even in the absence of mood changes.

Knowledge of the medications that a patient is taking is also important. Medications used to treat medical conditions can interact with psychotropic medications (Ferrando et al. 2010; Sinclair et al. 2010; Zorina et al. 2013). Many individuals receiving psychiatric treatment are taking multiple medications, and this magnifies the likelihood of drug-drug interactions (Haueis et al. 2011; Mojtabai and Olfson 2010; Sandson et al. 2005; Thomas et al. 2010). Patients may also be taking nonprescribed medications such as nutritional supplements or herbal products (Freeman et al. 2010; Meeks et al. 2007; Ravindran and da Silva 2013), which can interact with psychotropic medications, influencing therapeutic benefits or side effects. Side effects of somatic treatments for psychiatric conditions can also produce or increase the risks of preexisting medical conditions (Goldberg and Ernst 2012). Other medication effects can mask physical findings that are important to clinical decision making. For example, a beta-adrenergic receptor antagonist can blunt changes in vital signs (e.g., tachycardia, elevations in blood pressure) that signal alcohol or benzodiazepine withdrawal. In addition, medications can be associated with false positive results on toxicology testing (Brahm et al. 2010; Rengarajan and Mullins 2013) or modify other laboratory findings leading to an incorrect diagnosis. Lack of information or confusion about prescribed medications and dosages can also contribute to medical errors (Fitzgerald 2009; Procyshyn et al. 2010; Tully et al. 2009).

Given the above, an understanding of the patient's medical status is important to 1) properly assess the patient's psychiatric symptoms and their potential cause, 2) determine the patient's need for medical care, and 3) consider potential effects on the patient's medical conditions or related treatments when choosing among psychiatric treatments.

Potential Benefits and Harms

In an initial psychiatric evaluation, determining whether or not the patient has an ongoing relationship with a primary care health professional is potentially beneficial from several vantage points. In patients who are already receiving medical care, communication with the primary care professional could be useful in coordinating assessments and treatment. If the patient has had a recent medical assessment, the psychiatrist may be able to review the results of the history, physical examination, and laboratory or imaging findings in lieu of a direct assessment of the patient. Such information is often important in formulating a differential diagnosis and considering the benefits and risks of potential treatment options. There are no plausible harms to determining if the patient has a relationship with a primary care professional.

Similarly, there are many potential benefits to ensuring that the initial psychiatric evaluation includes assessment of the aspects of the patient's medical health listed in statement 2. Signs and symptoms of illness may be consistent with either a psychiatric disorder or another medical condition. Differential diagnosis can be aided by knowledge of past or current nonpsychiatric medical disorders. Previously unrecognized medical illnesses may also be identified and addressed directly or by referral to another clinician. Baseline data about medical conditions may be useful later in interpreting physical signs and symptoms that emerge in the course of treatment, either related to progression of underlying medical conditions or as side effects of psychiatric treatments.

The potential benefits of knowing the medications that a patient is taking are also multifaceted. Use of prescribed medications, over-the-counter medications, vitamins, nutritional supplements,

and herbal products can be associated with psychiatric signs and symptoms that would be relevant to differential diagnosis. These medications can also interact with medications for psychiatric conditions and thereby influence treatment planning.

The cost of assessing these aspects of the patient's medical health is difficult to separate from the overall cost of an initial psychiatric evaluation, which varies depending on the patient, the setting, and the model of payment. When time within the initial psychiatric evaluation is used to focus on assessment of aspects of the patient's medical health, there could be less time available to address other issues that are of importance to the patient or of relevance to diagnosis and treatment planning.

Implementation

As described in the definition of "assessment" (see Glossary of Terms), there are a variety of ways clinicians may obtain recommended information about a patient's medical health during an initial psychiatric evaluation. Typically, an evaluation involves a direct interview between the patient and the clinician. In some circumstances (e.g., an evaluation of a patient with severe psychosis or dementia), obtaining information on history and a review of symptoms may not be possible through direct questioning. When available, prior medical records, electronic prescription databases, input from other treating clinicians, and information from family members or friends can raise previously unknown information. Added details or corroboration of information obtained in the interview is often helpful, since gaps in patient report can arise from ordinary errors in comprehension, recall, and expression (Redelmeier et al. 2001; Ryan et al. 2013; Simon et al. 2012). Flexibility may be needed in framing questions in terms that patients or family members are able to understand. For example, patients with intellectual disability or neurocognitive disorders may have difficulty in understanding questions as initially posed. In older individuals, difficulty understanding questions may signal unrecognized impairments in hearing or in cognition that would benefit from more detailed evaluation.

In some clinical contexts, such as a planned outpatient assessment, patients may be asked to complete an electronic- or paper-based form that inquires about key elements of the medical history and review of systems. Such forms may be completed prior to the visit or upon arrival at the office and can serve as a starting point to explore reported symptoms or historical information. Discussion may also be initiated with a brief open-ended question, which is conducive to capturing the nuances and narrative of the patient's concerns. Thus, with the sexual history, a patient may be asked "Do you have any sexual concerns or problems that you would like to discuss?" or "Are you sexually active?" (Althof et al. 2013), with follow-up questions asked (e.g., about contraceptive use), as indicated. Laboratory data or findings of electrocardiography, imaging studies, other radiological investigations or neuropsychological testing may also provide clues to past or current medical conditions.

These recommendations should not be viewed as representing a comprehensive set of questions relating to assessment of medical health, nor should they be seen as an endorsement of a checklist approach to evaluation. For example, there are frequent overlaps between medical health and substance use disorders, but recommendations for substance use assessment are provided in "Substance Use Assessment." Depending on the clinical setting and type of treatment, some information may be more or less relevant to obtain as part of the evaluation. Thus, it may be important to assess diseases and symptoms of disease that have a high prevalence among individuals with the patient's demographic characteristics and background, such as infectious disease in a patient who uses intravenous drugs or pulmonary and cardiovascular disease in a patient who smokes. Identifying a family history of hyperlipidemia or early cardiac death would be more relevant to obtain in an individual with multiple cardiac risk factors or a risk for metabolic syndrome. A detailed review of systems may be less crucial in a generally healthy individual who receives regular primary preventive care, although the Current Procedural Terminology and the U.S. Centers for Medicare and Medicaid Services describe the review of systems as a part of a comprehensive evaluation (Centers for

Medicare and Medicaid Services 2014; Schmidt et al. 2010). In patients who will be treated with psychotherapy by the psychiatrist who is performing the evaluation, some aspects of the history (e.g., sexual and reproductive history) may be more appropriate to defer until later in treatment.

Information may also be more or less relevant to obtain based on the timing of a clinical event. Time-based terms such as "current," "recent," or "past" are often used in clinical contexts but are impossible to define precisely and introduce vagueness into recommendations. With some information (e.g., allergies), details are essential to obtain regardless of when the clinical event may have occurred. With other information (e.g., minor surgical procedures, minor trauma), more recent events may be of relevance, whereas events in the distant past would be of minimal importance to elicit in a thorough fashion.

To determine whether the patient has an ongoing relationship with a primary care health professional requires gathering additional information besides a simple recording of the clinician's name. Some patients may be assigned to a primary care health professional, yet rarely meet with the individual or receive preventive care. Under such circumstances, inquiring about the patient's relationship with his or her primary care practitioner can be a starting point for improved access to quality health care and preventive services. For individuals who are receiving care from multiple specialty physicians, initial questions about having a primary care health professional can be followed up with additional questions about other clinicians who are providing them with care. Obtaining a complete and accurate list of the patient's medications can be challenging but has many implications for diagnosis and avoiding medication errors. When asked about the medications that they are taking, most patients think in terms of prescriptions they receive at a pharmacy, but they may not report receiving long-acting injectable antipsychotic medications, oral or long-acting injectable contraceptives, or nonprescribed medications (e.g., over-the-counter medications, vitamins, herbal products, nutritional supplements) unless specifically asked. Approaches that have been employed to develop an accurate medication list include using a structured format for the medication history (Drenth-van Maanen et al. 2011) or involving hospital-based clinical pharmacists or pharmacy technicians in taking a medication history (Brownlie et al. 2014; Kwan et al. 2013). With the use of electronic prescribing and electronic health records, information on patients' previous medications will be increasingly available to clinicians. Again, these data can be used as a starting point for discussion but still require verification by the clinician to ensure that the electronic information is correct and consistent with the patient's current use of the medication and pattern of adherence. Particularly with older individuals, it can be useful to remind patients to bring a current list of their medications and bring all of their medication bottles from home at the time of the visit. If a patient's recall of medications is inconsistent or erroneous, it may signal a need for detailed cognitive examination to identify possible neurocognitive impairments that would pose medication safety risks or interfere with adherence.

The physical examination may be performed by the psychiatrist, another physician, or a medically trained clinician. Elements of the examination, such as vital signs, height, and weight, may also be obtained by nursing staff or a medical assistant. The results of the patient's most recent physical examination may also be relied on in obtaining information about the patient's physical status. Considerations influencing the decision of whether the psychiatrist will personally perform the physical examination include potential effects on the psychiatrist-patient relationship, the purposes of the evaluation, and the complexity of the medical condition of the patient. The timing and scope of the examination will vary according to clinical circumstances. In some individuals, portions of the examination (e.g., vital signs) may be important to perform as soon as possible to identify an urgent need for referral (e.g., in a patient with symptoms of alcohol withdrawal). In other individuals, it may be appropriate to defer the examination. For example, the physical examination of an otherwise healthy patient with paranoia may be deferred to a different clinician or a more appropriate time or setting. Depending on the setting and type of treatment, transference issues could arise and interfere with effective treatment if the psychiatrist conducts the physical examination himself or herself. If physical assessments are done as part of the evaluation rather than relying on examinations by other health professionals, provisions for chaperones should be considered.

Barriers to the use of these recommendations also exist, with a major barrier being constraints on clinician time and the need to assess many aspects of the patient's symptoms and history within a circumscribed period. Depending on the setting, general health status, and other clinical characteristics of the patient, clinicians may judge other parts of the evaluation as having a greater priority in planning initial treatment. In terms of conducting a physical examination, assessment of some organ systems may be viewed as being outside the scope of typical psychiatric practice. In addition, many psychiatrists, particularly in an outpatient setting, will not have access to a fully equipped room for conducting physical examinations. For medically ill patients, elements of the physical examination, such as gait, may not be possible to assess because of the severity of the patient's condition. In other individuals, the severity of their psychiatric illness may limit their ability to collaborate with a general medical history, medication history, review of systems, and physical examination.

GUIDELINE VII. Quantitative Assessment

Guideline Statements

APA suggests (2C) that the initial psychiatric evaluation of a patient include quantitative measures of symptoms, level of functioning, and quality of life.

Rationale

The goal of this guideline is to improve, during and after an initial psychiatric evaluation, clinical decision making and treatment outcomes.

The strength of supporting research evidence for this guideline statement is low. Two studies were identified that compared the use of a quantitative measure with clinical interview in patients who presented with a psychiatric symptom, sign, or syndrome and that looked for an impact on clinical decision making. Both studies were observational in design, and both examined the use of a scale that assessed only for delirium. Use of the scale was associated with greater diagnostic accuracy as compared with assessment without the scale, but the effect was weak and the study population was limited to patients in an intensive care setting.

Many studies have addressed the development, use, and statistical characteristics of psychiatric rating scales, but there have not been specific comparisons of these measures and nonquantitative assessment. In addition, there has not been specific examination of effects on clinical decision making. Nevertheless, other studies have examined potential benefits and utility of quantitative measures in psychiatric practice and contribute to the rationale for using ratings scales in clinical practice. For example, in addition to use of the self-rated 9-item Patient Health Questionnaire (PHQ-9) in depression screening, benefits have been found when the PHQ-9 is used for ongoing monitoring of depressed patients, either by psychiatrists (Arbuckle et al. 2013; Chung et al. 2013; Duffy et al. 2008; Katzelnick et al. 2011) or in primary care settings (Yeung et al. 2012). The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study (Trivedi 2009; Trivedi et al. 2007) and other studies (Allen et al. 2009; Bickman et al. 2011; Zimmerman and McGlinchey 2008a; Zimmerman et al. 2011; Zubkoff et al. 2012) have shown success in the clinical implementation of quantitative measures and in the use of measurement-based approaches to clinical decision-making (i.e., "measurement-based care"). An additional study that randomly assigned patients to monthly use of standardized measures compared with treatment as usual showed a reduction in inpatient days, although subjective outcomes were unaffected (Slade et al. 2006). In studies of psychotherapy, systematic rating scales have been used to provide "outcome-informed treatment" in which patients provide feedback on levels of distress as well as on facets of the therapeutic alliance and perceived benefits of treatment (Boswell et al. 2015).

The field trials for DSM-5 also demonstrated the feasibility and reliability of using the DSM-5 Level 1 Cross-Cutting Symptom Measure in clinical practice (Narrow et al. 2013). Furthermore, re-