Training Handout for the Online Training for Behavioral Health Care Managers

Thank you for taking the time to learn about Collaborative Care (CoCM) through our online training.

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About the AIMS Center

The purpose of the AIMS Center is to inspire providers, researchers, and decision-makers to transform healthcare and improve patient outcomes. We accomplish this by translating and researching evidence-based approaches to behavioral health integration. To learn more about the AIMS Center and our work, you can visit our website: https://aims.uw.edu/

Questions About the Online Training?

- Website: https://aims.uw.edu/online-bhcm-modules
- Email: aimstrng@uw.edu

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Initiate Treatment

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In This Module

- ✓ Treatment options
  - ✓ Biopsychosocial framework
  - ✓ Evidence-based, suitable for primary care
- ✓ How to discuss treatment with patients
  - ✓ Patient education
  - ✓ Shared decision-making
- ✓ Tracking treatment

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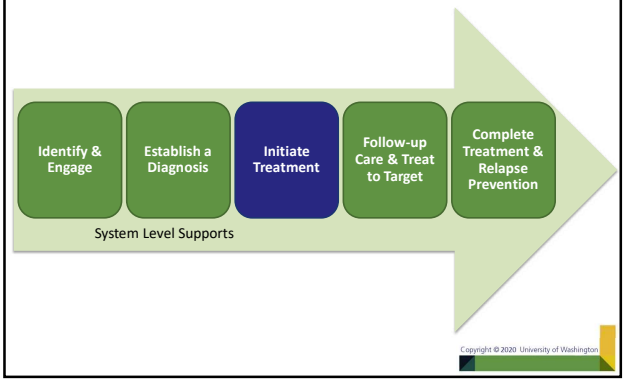
Initiate Treatment



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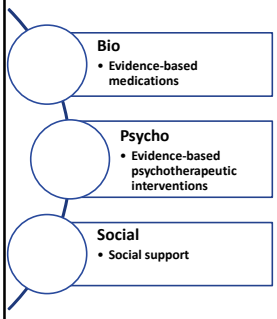
Treatment Options



- Offer BOTH medication and non-medication recommendations
- Supporting whole person treatment is important
- The treatment that WORKS is the best one
- Review all evidence-based treatment options available
- Discuss pros and cons of each option

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Medication Treatment

SSRI	SNRI
• Fluoxetine/Prozac • Sertraline/Zoloft • Citalopram/Celexa • Escitalopram/Lexapro • Paroxetine/Paxil • Fluvoxamine/Luvox	• Venlafaxine/Effexor • Duloxetine/Cymbalta
Other	**Common Augmentation**

• *Newer:*
  • Bupropion/Wellbutrin/Zyban
  • Mirtazapine/Remeron
• *Older:*
  • TCA (Amitriptyline, Nortriptyline)
  • MAOI
	• Buspirone/Buspar
	• Bupropion/Wellbutrin
	• Antipsychotic Medications (ex. Abilify or Seroquel)

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Review: Taking a Medication History

History
- Ask for list of past psychiatric medications
- What has been your experience with medications? Helped? Side effects?

Assess adherence
- How are you taking your medication(s)?
- Most people miss doses. How many times do you think you missed a dose of medication in the last week?
- How do you remember to take your medications?

Ask about concerns
- How is this medication working for you? What has improved? Anything worse? Quantify.
- Any side effects? What, when, how much do they bother you?
- Do you think this medication is helping you reach your goals?

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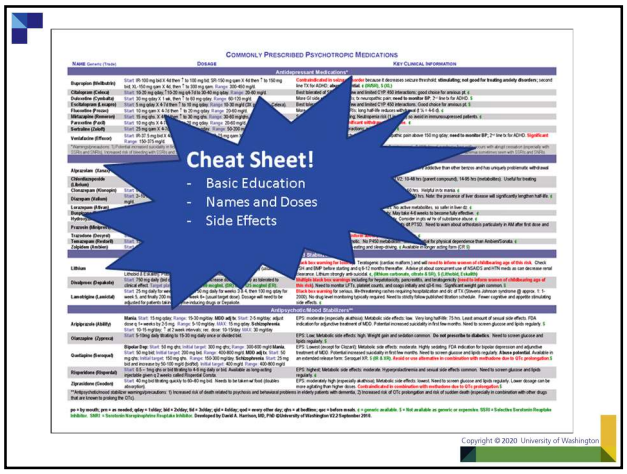

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Evidence-Based Brief Behavioral Interventions

- **Effective at improving symptoms**
- **Suited to primary care setting**
  - **Brief, 30-minute sessions**
- **Common examples include:**
  - **Problem-solving treatment (PST)**
    - Depression treatment
  - **Cognitive behavioral therapy (CBT)**
    - Depression and anxiety treatment
- **May require additional training**

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Problem-Solving Treatment (PST)

FAST
- Engage patient in what they care most about

FOCUS ATTENTION
- Training brain to solve problems

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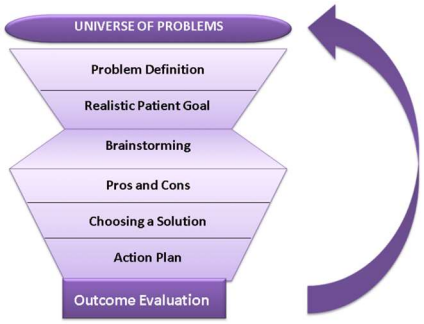
Problem-Solving Process



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Discussing Treatment Options

- **Review all evidence-based treatment options available**
  - Medications
  - Brief behavioral interventions
- **Discuss pros and cons of each option**
  - Allows patient to make an informed choice

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Discussing Treatment Options (cont'd)

- **The treatment that WORKS is the best one**
  - Patient-centered care means patient selects treatments, not clinician preference
    - Try to be unbiased when offering treatment options
- **Supporting whole person treatment is important**
  - "One size fits few"
  - Medication is not right for everyone
    - You can support medication therapy within scope of practice
  - Brief behavioral interventions are not right for everyone

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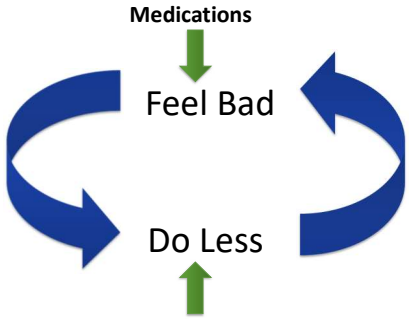
Patient Education



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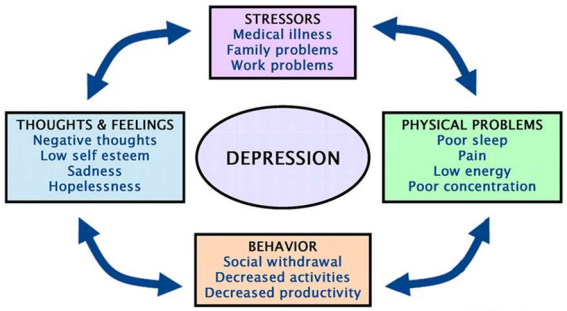
Patient Education: Cycle of Depression

Can use with patients when talking about treatment options



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A Collaborative Care Plan

- **Shared by the whole team**
  - Where will everyone be able to see it?
- **Include all treatment options**
  - Behavioral interventions, medications, referrals
- **Clear goals and roles**
  - A prioritized list, especially for complex patients
  - A clear "owner" for tracking goals

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Initiate Treatment for Depression

	PCP Approaches	Care Manager Approaches
	Evidence-Based Medication Treatment	
Biological Approaches	• Medications are safe and effective but patients will likely need adjustment in antidepressant treatment to achieve remission. • First line medications are SSRIs, SNRIs, bupropion, and mirtazapine, which all have comparable efficacy but have different side effect profiles.	• Support assessment of past medication trials. • Assess for potential barriers to engaging in medication management (e.g., cost or cultural barriers). • Support patients through making medication changes and troubleshoot adherence challenges.
	Evidence-Based Behavioral Treatment	
Psychosocial Approaches	• Validate behavioral interventions are treatment; consider giving the patient a prescription for these treatments. • Assess engagement with and reinforce behavioral treatment during medical visits.	• There are a number of evidence-based behavioral interventions for depression that can be delivered briefly in primary care medicine. • First line treatments include BA, CBT, IPT, and PST.

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PRACTICE

Example Case

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Case Part 1

- A 53-year-old man presents to his PCP with a chief complaint of "not sleeping enough, having headaches, and feeling run down." For the last 4 months, he has been waking up too early in the morning and cannot get back to sleep. During the day he is exhausted and is having trouble focusing when he's at work. His chronic back pain has increased, so he has been staying at home and has stopped exercising. He has tried everything he can think of to "break out of this rut," but feels like it is pointless and is ready to give up.
- The PCP administered a PHQ-9 (the patient scored 18) and then asked the patient about suicidality. After discussing the symptoms on the PHQ-9, the patient said that he never thought of himself as depressed before. At the first visit, the PCP conducted a safety assessment to follow up on the patient's thoughts of giving up. The patient revealed he has thought about jumping off a local bridge but he feels he does not have the courage to go through with it. The patient had never told anyone this, but felt relieved that his PCP knows about this, so they could start to address this.
- At the initial visit the PCP conducted additional screening for anxiety, which revealed that the patient's GAD-7 score was 6. The patient's review of systems was notable for headaches along with exacerbation of his chronic back pain. He reported minimal alcohol use on the CAGE and does not use opioids. He has hypertension, but his blood pressure was in the normal range on hydrochorothiazide and his physical exam including neurological exam were unremarkable. No lab tests were indicated. . The primary care provider expressed confidence to the patient that he would be able to improve and introduced the patient to the care manager for further evaluation and treatment.
- The care manager conducted a comprehensive assessment of the patient and learned that he has been more irritable at home with his wife and children for the past six months. He has also stopped going out with friends. In the last two weeks he has been late to work four times because he can't get himself to get started in the morning. Additional history revealed he had a similar episode in the past when he was about 20 years old when he was having trouble with his coursework at college; he described it as a very stressful time. He talked with a college counselor for several months, and then things improved before he graduated. To manage his stress recently, the patient reports he has started smoking cigarettes again after having quit four years ago. The PCP had conveyed the patient's thoughts of suicide to the care manager who also assessed the patient's safety as part of the comprehensive assessment. With the patient's permission, the care manager contacted the patient's wife in his presence. Together they discussed his passive suicidality, which she had not known about. She was grateful to be included in the assessment and had no additional concerns. The care manager invited the wife to contact the treatment team should she have new concerns about the patient's safety, and the patient felt reassured that everyone was on the same page.
- As part of the care manager's initial comprehensive assessment, the care manager administered screening instruments for PTSD (PCL-5), and bipolar disorder (CIDI-3), both of which were negative. The care manager screened for substance abuse with the GAINS which was negative and confirmed that the patient did not have a prior history of drug or alcohol problems. The care manager and patient discussed the provisional diagnosis of major depression and its treatment, as well as the connections between depression and chronic pain.

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Brief Summary of Patient's Clinical Presentation

- 53-year-old male
- "not sleeping enough, having headaches, and feeling run down"
- Chronic back pain
- PHQ-9 score is 18
- GAD-7 score is 6
- Passive suicidal ideation

What are some interventions to consider offering this patient?

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Case Part 2

- The care manager and psychiatric consultant discussed the patient's presentation. The PCP had asked whether fluoxetine would be appropriate for the patient. The psychiatric consultant suggested considering bupropion as an initial antidepressant given its efficacy in supporting smoking cessation. A titration schedule was provided to escalate the dose to the therapeutic range and monitor response with a PHQ-9 over four to six weeks.
- The psychiatric consultant and care manager determined that the care manager would offer Problem Solving Treatment (PST) to the patient and help support the antidepressant management. Problem Solving Treatment was selected because the brief nature of the intervention (30-minute visits) fits the patient's desire to keep meetings short. Additionally, the patient reported that he would like to focus on re-engaging in work and social activities, but was having a hard time getting started.
- In the first PST meeting, the care manager explained the rationale behind PST and what to expect from treatment. The care manager first described that when one is depressed and in pain, the tendency is to avoid physical, social and work activities because these activities either seem too hard to start or there is an expectation that they will not be successful or enjoyable. Unfortunately, the less one does, the more depressed and pain one feels, something the patient had reported in his initial evaluation. The care manager then explained that PST teaches and empowers patients to solve the here-and-now problems contributing to their depression and helps increase his ability to feel engaged in life again. The care manager was already familiar with the activities the patient had stopped engaging in and thus was able to immediately help the patient identify activities that were enjoyable and easy to implement. In discussing the various activities he had stopped doing, the patient indicated he felt he wanted to do two things: extending his walks with his dog beyond what he was already doing and inviting a friend along with him on these walks. The care manager consulted with the PCP about the activities the patient could safely engage in, given his chronic back pain, and also worked with the psychiatric consultant regarding the pain relieving effects his antidepressant might confer to assist in gradual increase in physical activity.
- Following the care manager's recommendation, the patient scheduled a follow-up visit with his PCP. The care manager updated the PCP about the treatment plan and the psychiatric consultant's recommendations for antidepressant medication. The PCP prescribed bupropion SR 150mg daily. The PCP arranged follow-up with the patient, and reinforced the role of the care manager in coordinating care and the value of PST for depression.

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Brief Summary of Initial Treatment Plan

- **Care manager and psychiatric consultant meet to discuss:**
  - Patient's presentation
  - Initial treatment plan
- **Initial treatment plan for this patient:**
  - Bupropion with titration schedule
  - Problem-Solving Treatment

Initial treatment plan consists of both medication and brief behavioral interventions.

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Case Part 3

Consider how the care manager and psychiatric consultant think about appropriate treatment options for this patient.

- After four weeks in treatment, the patient's sleep was improving and his energy improved, but his PHQ-9 score remained elevated at 14. The care manager notified the PCP and the patient's bupropion SR dose was increased to 150mg twice daily (morning and afternoon) as suggested by the . By week 8, the patient reported his concentration was improving at work, his back pain had improved, and his PHQ-9 score was down to 8. The patient continued on bupropion 150mg twice daily and ongoing follow-up with the care manager for behavioral activation. The care manager taught the patient ways to manage his negative thoughts.
- At week 12, the patient's PHQ-9 dropped to a 4 and he reported that his pain was more manageable. The patient indicated that he had added to his walking routine with his dog and twice-weekly aquarobics class at his local community center. He reported feeling better connected socially, and while he occasionally had bad pain days, he felt he had a plan to manage them well. The patient also reported a decrease in irritability, which resulted in better relationships with his family. The care manager recommended that the follow-up meetings be reduced to every other month.
- After an additional four months, the patient's PHQ-9 score dropped to a 1 and he reported continued success in social engagement, even when his back bothered him. The patient and care manager began to discuss relapse prevention plans. He understood the need to remain on his antidepressant medication for a minimum of six months even though he was feeling better, but that he might consider a longer course given his prior history of a depressive episode.
- At the final meeting, the care manager and patient developed a detailed relapse prevention plan that included continuation of his medication for another year, and a plan to continue his pleasant activities (walking, swimming, socializing with family and friends, volunteering at the local church on Sundays). The plan also included the patient continuing to track his symptoms on his own as well as a plan to monitor his "hot" symptoms, depression symptoms he felt are an indication he may need to check in with his doctor. The plan specified that if his PHQ-9 was above 5 for two weeks, experienced unremitting pain for one week, or began to drop his activities, he would contact his PCP for follow-up.

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This concludes the module.

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Introduction to Brief Behavioral Interventions

There is no handout available for this section.

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Psychiatric Medication Support

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In This Module

- ✓ Resources for continued and efficient learning about medication treatment of psychiatric disorders
- ✓ Process for taking a medication history
- ✓ Supportive tools to access medication information
- ✓ Assisting collaborative care team in management of commonly encountered medication treatment situations

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Why Do Care Managers Need to Know About Medication Use?

- Role of supporting successful medication treatment
  - Missed opportunities to support adherence in present-day treatment as usual
  - Adherence is a big deal
    - Actual real-life medication adherence is probably less than 50%!
- Familiarity with the reasons why medication trials fail
- Management of common benign side effects can facilitate adherence

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Ongoing Learning Is the Core Task

- The medication knowledge base is massive
- Don't rely on your memory alone
- The key is to know where to find:
  - Good information
  - In a useful format
  - Quickly

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Good Information Sources

- AIMS Center resources
  - Commonly Prescribed Psychotropic Medications
- Your psychiatric consultant

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How to Make Use of Your Psychiatric Consultant

- Ask for explanations
  - It makes everyone smarter
  - "I'd like to know about..."
  - "The PCP read @ .... in the NY Times..."

Every consultation is an opportunity to learn!

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TAKING A MEDICATION HISTORY

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Review: Taking a Medication History

History

- Ask for list of past psychiatric medications
- What has been your experience with medications? Helped? Side effects?

Assess adherence

- How are you taking your medication(s)?
- Most people miss doses. How many times do you think you missed a dose of medication in the last week?
- How do you remember to take your medications?

Ask about concerns

- How is this medication working for you? What has improved? Anything worse? Quantify.
- Any side effects? What, when, how much do they bother you?
- Do you think this medication is helping you reach your goals?

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Taking a Medication History (continued)

- **Determine current medications**
  - **Ask about additional items**
    - **Supplements**
    - **Over the counter medications**
    - **Medications from family or friends**
  - **Ask about items taken less often than prescribed**

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Prior Psychiatric Medications

- Questions to ask patients
  - Name of medication
  - What did you think it was for?
  - What was the dose?
  - How long did you take it?
  - Why did you stop?
    - Got better
    - Got worse
    - Side effects (weight, sexual dysfunction, dry mouth, movement problems)
    - Forgot

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Special Medication History Situations

- Controlled substances
  - Benzodiazepines
  - Opioids
  - "Muscle relaxants"
- Stimulants
  - Often misused, sold
- Thyroid
  - Tied to mood disorder, use of lithium
- Corticosteroids (Prednisone, etc.)
  - Can affect mood

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Assess Adherence

- Questions to ask patients
  - How are you taking this medication?
  - Most people miss doses. How many times do you think you missed a dose of medication in the last week?
  - How do you remember to take your medications?

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Patient Concerns

- **Questions to ask patients**
  - How is this medication working for you? What has improved? Anything worse? Quantify.
  - Any side effects? What, when, how much do they bother you?
  - Do you think this medication is helping you reach your goals?

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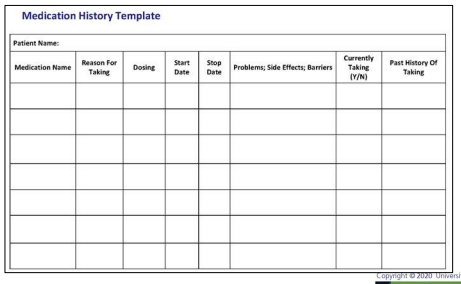
Staying Organized When Taking a Medication History

- **An outline is useful**



Medication History Template

Patient Name:							
Medication Name	Reason For Taking	Dosing	Start Date	Stop Date	Problems; Side Effects; Barriers	Currently Taking (Y/N)	Past History Of Taking

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SUPPORTING MEDICATION USE

Commonly Encountered Clinical Situations

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Educating Patients About Psychiatric Medications

- Manage misconceptions
  - "Medications are addictive - I will become dependent on them"
  - "Medications are mind-altering drugs"
  - "Medications are 'happy pills' or 'will make me a zombie'"
  - "Once I get better, I won't need medication any more"
  - "I only take medication when I have symptoms"
- Anticipate common questions
- Give verbal and written information about medications and plan
- Ask for concerns about medications or plan
- Look for help from the team to help fill in details

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Starting Treatment with Medications

A Common Question from Patients You Can Ask Your Psychiatric Consultant

- "How did the doctor decide which antidepressants to use?"
  - All are equally likely to be effective
  - Different people respond differently, but can't tell ahead of time
  - Choose practically, on the basis of fewest side effects or affordability
  - Will likely have to try more than one

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Starting Treatment with Medications

Common Questions from Your Patients

Common Questions	How You Might Respond
"When will the medications work?"	"We won't be able to make a decision about whether this dose of medication is effective for about 4 weeks." "It can take 1-6 weeks for patients to start feeling better."
"Will I be able to [keep exercising]?"	Focus on realistic goals and timetables with the patient.
"What will getting better look like?"	Keep in mind, the patient may be able to tell you. The PHQ-9 is good for detecting gradual improvement. The patient may be able to say "I'm not perfect, but I guess I'm better than I was."

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Starting Treatment with Medications: Anticipate Challenges

- Questions to ask patients
  - How likely are you to take the medication every day?
  - Do you think the medication will help you?
  - What might get in the way of taking your medication?
  - Will your family and friends support you?
  - How will you remember to take it?

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Planning for Follow-up Sessions

- Frequent early follow-up is vital
- Second session disappointment
  - There might be little improvement
  - Patient may feel the medication isn't helping at all
  - "This is ordinary – not a sign that you're not getting well – we are here for you"

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Follow-up Sessions

Common Questions from Your Patients

Common Questions	How You Might Respond
"What if my medication doesn't work?"	"There are many options and it can sometimes take a few trials to find the right medication for you."
"What if I have side effects?"	"Tell us about it – the team will work together to help you with this."

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Follow-up Sessions: Adherence Challenges

- **Anticipate and troubleshoot treatment adherence challenges**
  - **Money**
    - **No point if a medications isn't covered**
  - **Prior authorizations/insurance**
  - **Side effects**
  - **Family disapproval**

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Recognizing Whether What Patient Reports Is "Normal"

- **Minor complaints and side effects – or are they?**
  - "I feel restless."
  - "I have this little red spot."
  - "My back hurts."
  - "I haven't slept for three days."
- **Ask the primary care team for help with assessing/managing side effects**
  - Stay within your scope of practice

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Discussing Common Side Effects of Depression Medications

- **Sexual dysfunction**
  - **Over 50%**
  - **You have to ask to find out – rarely volunteered**
- **Agitation**
  - **Often in the beginning, and transient (2-3 days)**
- **Precipitation of mania**
- **Ask the primary care team for help with assessing/managing side effects**

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Enhancing Adherence: What If the Patient Wants to Stop Medication?

- Good reasons to stop a medication
  - Intolerable side effects
  - Dangerous interactions with necessary medications
  - The medication was not indicated to start with (as can be the case with bipolar depression)
  - Medication has been at maximum therapeutic dose without improvement for 4-8 weeks
- Things you can do to support the patient
  - Direct to PCP to discuss length of treatment
  - Discuss continuing medications even when feeling better
  - Help patient write down questions
  - Get input from psychiatric consultant

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Discuss Relapse Prevention Planning

- Relapse prevention
  - Role of medications
  - Focus on staying well
  - Warning signs
  - Role of early intervention

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Enhancing Adherence

Relapse Prevention

- Reframe the ongoing use of medications
  - A personal decision
  - Enhancing quality of life
  - Reinforce positive effects
  - "You can come back to us."
  - Sometimes (e.g., bipolar) "It is your call. If you were my [brother], I would recommend continuing."

For many people, mood stability is precious, and can't just be switched back on when lost.

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Assisting PCP & Team in Effectively Providing Care

- Understanding and following algorithms
  - So patients can use their medications effectively
- Getting timely consultation
  - As opposed to waiting too long before changing or clinical inertia

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Depression: Startup Procedures

- Inform and educate
- Common practices
  - Half-doses for first two weeks
    - Lessens risk of initiation-related agitation
    - Example, fluoxetine 10 mg daily
  - Then changes every four weeks
    - Before this, too soon to call response or failure
- "Why does it take so long?"
  - "The brain has to actually rebuild itself and it takes a while to send out for parts."

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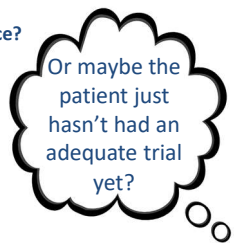
What to Do When Depression Is Not Responding to Treatment

- With your team, consider:
  - Wrong diagnosis?
  - Problems with treatment adherence?
  - Insufficient dose/duration of treatment?
  - Side effects?
  - Initial treatment not effective?
  - Other complicating factors?
    - psychosocial stressors/barriers
    - medical problems/medications
    - substance use
    - other psychiatric problems



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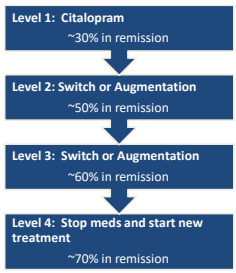
Depression: What to Do When Medication Trial Doesn't Work

- STAR-D trial
  - 4-5 trials needed to get most people better
- All interventions appear equally likely (or unlikely) to work:
  - Add Cognitive Behavioral Therapy (CBT)
  - Change dose
  - Augment
    - Bupropion
    - Atypical antipsychotic (metabolic risk)



Help the patient give each trial a chance to work!

Source: NIMH

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Anxiety

- First line is SSRI antidepressant
- Benzodiazepines or "benzos" (Xanax, Ativan, Valium…)
  - Widely used
    - Acceptable to patients
  - Downsides
    - Addiction
    - Psychomotor compromise
    - Dependence
    - Often create difficulties for clinic
  - Some clinics have blanket prohibition of benzodiazepines
    - Controversial

- Lots of appointment time spent negotiating
- Some patients will accept nothing else
- Psychiatrists and PCPs vary on this issue

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Lab Monitoring

- Most medications need some monitoring
- Helpful to know what is normal
  - PCP and Psychiatric Consultant are responsible for monitoring guidelines and normal levels
  - Care Managers can help with tracking, scheduling lab draws, and sending reminders to patients
- Reinforce with patients
  - "This is good medicine."

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Key Takeaways

- Learning about medications is an ongoing task
- Know how to find good information quickly
- Get familiar with common scenarios
- Cultivate your team and your psychiatric consultant

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This concludes the module.

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Caseload Management

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In This Module

- **Practice using a registry**
- **Identify patients who need attention & next steps**

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Caseload Overview **Report Run on 10/11/2017**

Patient ID	PHQ-9 Scores		GAD-7 Scores		Contacts						Flags
	First	Last	First	Last	Initial Assessment	Follow-up	Psych Note	Relapse Prevention Plan	Number of Sessions	Weeks since initial assessment	
1	23	10*	7		5/5/2017	8/15/2017	8/23/2017		14	25	
2	17	4	4		11/18/2016	10/3/2017	4/12/2017		18	46	
3	16	7	6		5/17/2017	10/10/2017	10/3/2017	10/10/2017	14	24	
4	25	25	2		8/31/2017	10/11/2017	9/6/2017		4	5	
5	20	12	10	10	11/16/2016	10/1/2017	6/14/2017	8/31/2017	16	46	
6	19	9	19	6	5/31/2017	9/12/2017	6/28/2017		7	18	
7	11	12	19	13	8/22/2017	10/10/2017	8/23/2017		3	6	
8	21	5	13	5	8/10/2017	9/16/2017	9/13/2017		8	10	
9	9	8*	13	6*	8/19/2017	9/30/2017	9/30/2017		2	7	
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66

Care Manager Weekly Task List

1. **Identify patients with no contact in the past two weeks.**
2. **Identify patients with a score of 10 or below or whose PHQ-9 score has reduced by at least 50%, that are ready for relapse prevention.**
3. **Identify patients who have been in treatment for 10 weeks or more without significant improvement (defined as a score of 10 or under or at least a 50% reduction in PHQ-9 score).**
4. **Identify patients with no psychiatric consultation note (or whose most recent note is more than 10 weeks old) and have scores on the PHQ-9 that are over 10.**
5. **Identify patients with acute safety risks.**

67

Care Manager Weekly Task List

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68

1. Identify patients with no contact in the past two weeks.

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4	25	25	2		8/31/2017	10/11/2017	9/6/2017		4	5	
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Patients with No Contact in Past Two Weeks

- **What would be appropriate next steps or responses for patients you haven't seen in over two weeks?**
  - **Schedule time for phone and other outreach efforts this week.**
  - **If anyone hasn't had a contact in 2 months, consider discharging them.**

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Care Manager Weekly Task List

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4. Identify patients with no psychiatric consultation note (or whose most recent note is more than 10 weeks old) and have scores on the PHQ-9 that are over 10.
5. Identify patients with acute safety risks.

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2. Identify patients with a PHQ-9 score of 10 or below , or a 50% or greater decrease from their first PHQ-9 score.

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72

Not All Patients Will Achieve Remission

- Some patients will have improved as much as appears possible given their circumstances
  - Life circumstances
  - Complex psychiatric situations
- Appropriate to move these patients to relapse prevention
  - First discuss with patient and psychiatric consultant
- Other patients may still have the potential to improve but will need specialty care
  - Appropriate to refer these patients rather than move to relapse prevention status
  - Some patients may stay on your caseload while waiting for their referral to specialty care; these patients may benefit from your support in bridging care

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Care Manager Weekly Task list

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4. Identify patients with no psychiatric consultation note (or whose most recent note is more than 10 weeks old) and have scores on the PHQ-9 that are over 10.
5. Identify patients with acute safety risks.

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3. Identify patients who have been in treatment for 10 weeks or more without significant improvement (defined as a 50% or greater decrease in PHQ-9 score or a PHQ-9 score of 10 or below).

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75

Patients in Treatment for 10+ Weeks Without Improvement

- **What are actions you could take for these patients?**
  - **Is the patient engaged? If not, develop a plan and allot time for engagement.**
  - **Determine what change in behavioral treatment may be required to help achieve improvement. (If using CBT without improvement, what other evidence-based treatment could be helpful? Behavioral activation?)**
  - **Flag the patient to discuss during your next psychiatric consultation.**

76

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4. **Identify patients with no psychiatric consultation note (or whose most recent note is more than 10 weeks old) and have scores on the PHQ-9 that are over 10.**
5. Identify patients with acute safety risks.

77

4. Identify patients who have no psychiatric consultation note (or whose most recent note is more than 10 weeks old) and who have PHQ-9 scores over 10.

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78

Patients with No Recent Psychiatric Consultation Note and PHQ-9 Scores over 10

- **What is one registry function you could use to be sure you discuss these patients during consultation?**
  - **Flag the patient in the registry to discuss during your next psychiatric consultation.**
  - **The flag prompts the psychiatric consultant to review the case prior to the caseload review.**

79

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5. **Identify patients with acute safety risks.**

80

5. Identify patients with acute safety risks.

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81

Patients with Acute Safety Risks

- **If you knew you had a patient with an acute safety risk, how could you use the registry to be sure to contact the patient frequently?**
  - **Flag the patient for higher safety risk to remind yourself to call them and to remind the team to frequently review the status of the patient.**
    - You should have already addressed the safety concern with the patient during their visit.
  - **Remove flag once the patient is no longer at acute risk.**

82

Next Steps

- **Determine how to intensify treatment**
  - **Add new treatment modality**
  - **Switch treatment modality**
  - **Increase contact**

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This concludes the module.

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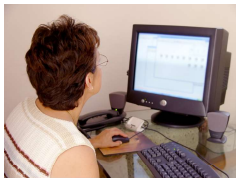
Caseload Review with the Psychiatric Consultant

85

In This Module

- ✓ The structure and organization of caseload review
- ✓ Strategies for effective caseload review



86

Using Psychiatric Consultation Time Efficiently

Use the registry as a tool to help choose patients likely to need reviewing:

- Acute safety risk
- Medication side effects
- High PHQ-9 scores
- Patients not responding to treatment
- Patients ready for discharge
- PCP questions
- Diagnostic complexity

87

What Information Does the Psychiatric Consultant Really, Really Need?

- Risk assessment
- Symptoms and history supporting diagnosis
  - Including those suggesting more serious conditions
- Medical history
- Medication list
- Psychiatric treatment history

88

Model Consultation Hour

- Set an agenda
- Brief check-in
  - Changes in the clinic
  - Systems questions
- Identify patients and conduct reviews
  - Follow-up on prior week's recommendations
  - Presentation to consultant of cases for review
  - Diagnostic and treatment decision making
  - Action planning, next steps
- Wrap up
  - Celebrate successes!
  - Confirm next consultation hour
  - Send any educational resources discussed

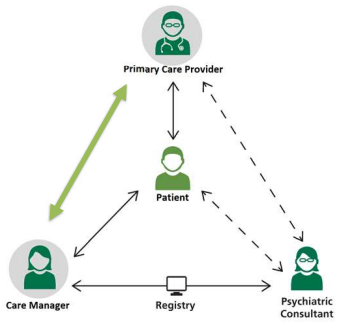
89

Planning Your Next Steps

- Who will do what?
  - Call patient
  - Call pharmacy
  - See family
  - Talk to PCP
  - Write progress notes / consults
  - Make referral
  - Go home, look something up and report back
  - Etc.
- When is our next meeting?
- How can we be in touch in between if needed?

90

Communication: Care Manager and Primary Care Provider



91

This concludes the module.

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Case Presentation Skills

94

In This Module

✓ **How to give brief, focused clinical presentations to the psychiatric consultant**

95

Translating Between Professions

- **The in-depth relationship you build is critical**
- **All the information you gather is important**
  - **However, it does not all need to be shared with the psychiatric consultant**

96

What Information Does the Psychiatric Consultant REALLY Need?

97

Key Components of Effective Case Presentation

- Suicidality/safety concerns
- Current symptoms
- History supporting diagnosis
- Medical history
- Psychiatric treatment history
- Current medications and other treatments

98

PRACTICE

99

Case Narrative #1: Billy

Billy is a 24-year-old gay male who works as a baggage handler at the airport. His treatment is covered by medical insurance through work. He lives in an apartment with 2 roommates, whom he knows from high school. He is referred from his PCP, to whom he complained that he was feeling tired all the time, at least since Christmas, though he has only missed work rarely. He is happy to have his job, which was all he could get after graduating from college, as many of his friends are not employed, but wishes he had something a little more intellectually stimulating, and doesn't feel like he has much in common with his coworkers. He has trouble falling asleep, lying awake for an hour or two in the evening, but can get up with his alarm. At times he feels like he has trouble focusing on the job, and his performance reviews are only ok, though he doesn't think the job is that hard. When asked, he does admit to some lowered mood, and feeling life is just not that great, over the last 4-5 months, and worse during the dark winter months. When he comes home from work, he often just vegetates in front of the TV, hardly even noticing what is on.

He has been treated briefly once in the past for "nerves", he thinks with an antidepressant, but only took it for 2-3 weeks, and then felt better and stopped because he wasn't sure he needed it and he thought he was putting on weight from it. He does not know if medication is a good idea for him or not, the idea of "not being normal" scares him a bit, but he is willing to talk about it and learn more.

Today, his PHQ-9 score is 15, and his GAD-7 score is 10.

He does not endorse symptoms consistent with mania, such as increased energy or irritability, grandiosity, racing thoughts, or reduced sleep without fatigue. He denies ever having heard voices or paranoid thinking.

He reports that his mother has been in treatment for depression with medication in the past, and that his father and brother have a history of alcoholism. Because he is afraid he is susceptible to this, he does not use alcohol or drugs any more, though he says he drank to intoxication and "used some weed and Ecstasy" when he was in school. He has some close friends, but has not had a significant other yet, which makes him worry whether or not he is always going to be alone, since he is "24 already, and not really even dating."

He denies any suicidal ideation, plan or intent, and also denies a history of suicidal behavior.

He is generally in good health, though somewhat overweight, he says because he "eats too much McDonald's." His BMI is 31. Reports that he does not have unsafe sex, though is concerned about sexually transmitted diseases, and has had himself tested for HIV and hepatitis, both of which were negative. He worries about his health when he has aches and pains, and thinks that he should exercise regularly, but doesn't find this enjoyable.

He does not have a significant history of traumatic experiences, and gets along fairly well with family of origin, though in his teens experienced stress with his family, who had difficulty with his coming out. His parents still live together, but argue a lot, and finds that when he is there he is always the referee, which makes him feel needed but stressed.

He would like to not be so tired all the time, and to "be making more progress" in his life. Working diagnoses:

Questions for psychiatric consultant:

Diagnosis?

Treatment?

Medications?

100

Psychiatric Consultation: Billy

- **Brief ID and psychosocial history**
  - Billy is a 24 yo single gay male. He is employed as a baggage handler and lives with friends
- **Suicidality/safety concerns**
  - No suicide risk
- **Current symptoms and history supporting diagnosis**
  - Some sx of depression over several months, including fatigue, lowered mood, difficulty concentrating, poor work performance. No bipolar symptoms for him or family. PHQ = 14, GAD = 10
- **Medical history**
  - No significant medical history; mildly overweight
- **Psychiatric treatment history**
  - Remote substance use only, prior prescription, medication unknown, stopped prematurely. No therapy.
- **Questions for the psychiatric consultant**
  - Establish diagnosis? Initial treatment plan?

101

You Try It! Case Narrative #2: Jane

Jane is a 75 yo female, married for the third time to her present husband for the last 15 years. She is retired, having worked for 20+ years as a veterinary assistant, which was for many years the only pleasure in her life, as she loves animals. She was unable to continue working after developing a fairly serious osteoarthritis, and now mostly putters around the house, trying to avoid her husband, who gets on her nerves because he is always watching the political news and shouting at either her or the television.

She is referred from her PCP, to whom she reported a long history of depression, dating back to her teenage years on and off. She had to be pressed to give this information, as she doesn't like to talk about it. She is at present taking amitriptyline 75 mg po hs for the depression, and says that "she has been better, she has been worse." She has some dry mouth from her medication, and says sometimes her head feels "cloudy." Her PHQ-9 this morning is 15, her GAD-7 is 6. She has intermittent insomnia, with awakening in the middle of night 3-4 nights a week, often sitting awake in the living room for hours. She does sometimes take over the counter sleep aids. She feels sad a lot, her kids have moved away and only call maybe once a month. She loves her dog and says that she doesn't know what she would do without him. She reports that she is a "great cook", but has lost interest in doing this, largely because there is no one to cook for besides just the two of them, and because she doesn't enjoy eating the way she used to. "Just enough to keep me alive, I guess."

She denies any suicidal ideation, plan or intent, and also denies a history of suicidal behavior. She has had problems with alcohol in the past, drinking up to a pint a day, and was once hospitalized after a fall, requiring detox over a few days. Has not had formal alcohol treatment, feels that she is too shy to attend AA, but has seen a therapist on and off over five years, last a year or two ago, and has not had a drink in about two years.

Her medical history is positive for hypertension, type II diabetes, and arthritis. She takes amitriptyline 75 mg hs, lisinopril 10 mg daily, metformin 500 mg twice daily, and Celebrex 200 mg daily.

She has had prior treatment with antidepressants including Prozac up to 60 mg a day for at least 12 months, [tolerated ok, but stopped being helpful], Zoloft up to 100 mg for 2 months [gave her headaches], venlafaxine up to 150 mg daily [caused her blood pressure to increase, but she thought that it was helpful.], and bupropion up to 100 mg per day ["made me too jittery"]. Her present dose of amitriptyline has been in place for about 9 months, but hasn't been adjusted. She was treated with psychoanalysis as a young woman, but had trouble fitting it in to her schedule, so stopped.

She does not endorse psychotic symptoms or manic symptoms such as such as increased energy or irritability, grandiosity, racing thoughts, excessive spending, poor judgment or reduced sleep without fatigue.

She does not report problems with forgetting, "besides the usual trouble with names."

When asked, she reports that she had a history of being touched improperly by a teacher when she was in junior high school. She did not report this to anyone, but was shocked and disappointed because she thought that this teacher saw something special in her, and she had trouble applying herself to school for a long time after this.
Goals: She had kind of given up on hoping, but supposes she would like to sleep better, and have a better mood.

Working Diagnosis:

Questions for psychiatric consultant:

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Psychiatric Consultation: Jane

- Brief ID and psychosocial history
  - Jane is a 75 yo cognitively intact woman. Married. Retired.
- Suicidality/safety concerns
  - No suicide risk at present
- Current symptoms and history supporting diagnosis
  - Chronic depression, either non-responsive or not-tolerant of Prozac 60, Zoloft 100, venlafaxine 150, bupropion 100; PHQ = 15, GAD = 6
- Medical history
  - Has hypertension (HTN), diabetes (DM), arthritis
- Psychiatric treatment history
  - History of alcohol dependence, abstinent for two years. Negative bipolar screen.
- Current medications and other treatments
  - Lisinopril, metformin, Celebrex, amitriptyline
- Questions for the psychiatric consultant
  - Treatment?

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Presentation for Follow-Up for Case Review

- Even shorter than the initial
- Include:
  - Brief reminder of patient and initial presentation
  - Relevant clinical and psychosocial updates
  - Current question(s)

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DP1

Back to Billy

- Brief reminder
  - Billy is 24 yo single gay male who presented with an episode of major depression.
- Clinical updates
  - Tolerating citalopram 20mg; PHQ score reduced from 15 to 12 after 8 weeks.
- Questions for the psychiatric consultant
  - Additional adjustment for medication?

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Slide 105

DP1 Change Clinical Updates to:
- "Tolerating citalopram 20mg; PHQ score reduced from 15 to 12 after 8 weeks"
- CONSIDER ADDING SOMETHING RE: NON-MED TREATMENT

Diane Powers, 7/5/2018

Jane Continued – You Practice!

Jane was started on a new medication duloxetine (Cymbalta) and is currently taking 30mg to target both her depression and her pain. She was told to go up to 30mg twice a day but was worried about her blood pressure. Her current blood pressure is normal.

You have seen her approximately every 3 weeks. She has also started to go to the pool 1-2 days a week. You have started to introduce Problem-Solving Treatment but patient has missed a couple of appointments. Still reporting significant depression and pain symptoms. PHQ: 15 → 13

You are wondering what to do next? Work on medications? Is it safe to go up on the dose? What about her level of engagement?

106

DP2

Back to Jane

- **Brief reminder**
  - **Jane is a 75 yo married woman with treatment-resistant depression, hypertension (HTN), diabetes (DM), arthritis.**
- **Clinical updates**
  - **Tolerating duloxetine 30mg. PHQ decreased from 15 to 13 over 8 weeks. Blood pressure normal.**
- **Questions for the psychiatric consultant**
  - **Safe for PCP to increase duloxetine? Other strategies to address depression and engagement?**

107

The Art of Case Presentation

- **Practice**
- **Improve with time!**

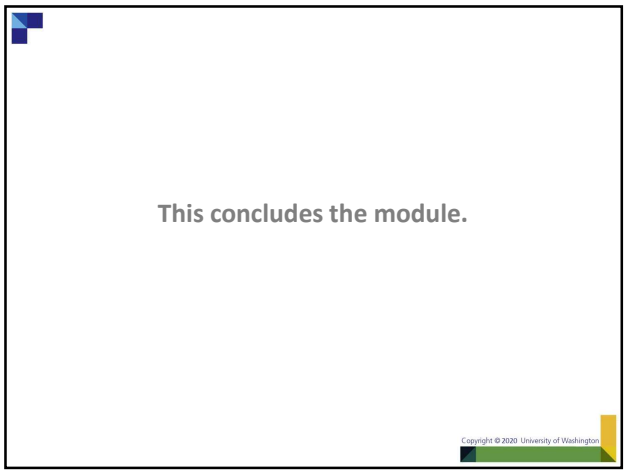
108

Slide 107

DP2 Remove : after headings (already missing after "medical history")

"treatment-resistant"

Clinical Updates
- Tolerating duloxetine 30mg. PHQ decreased 15 to 13 over 8 weeks. Blood pressure normal.
Diane Powers, 7/5/2018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Intensify Treatment

112

In This Module

- ✓ Intensify treatment through proactive treatment adjustments
- ✓ Determine next steps for caseload management

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Intensifying Treatment

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All The Places You'll Go!
Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
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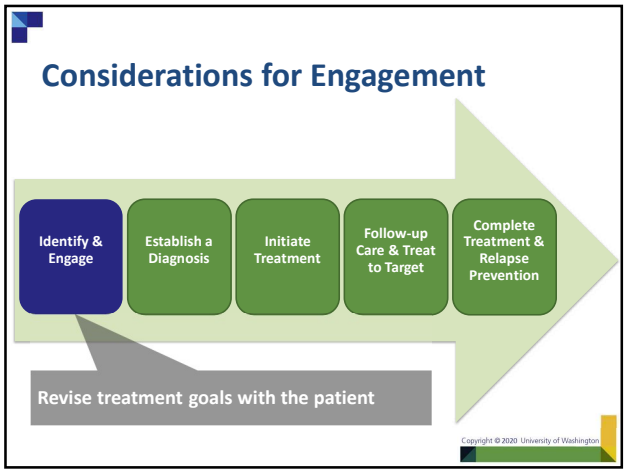
Considerations for Engagement
Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
Revise treatment goals with the patient
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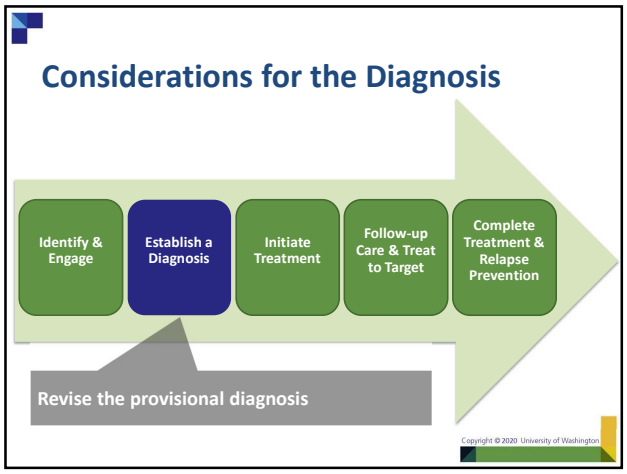
Considerations for the Diagnosis
Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
Revise the provisional diagnosis
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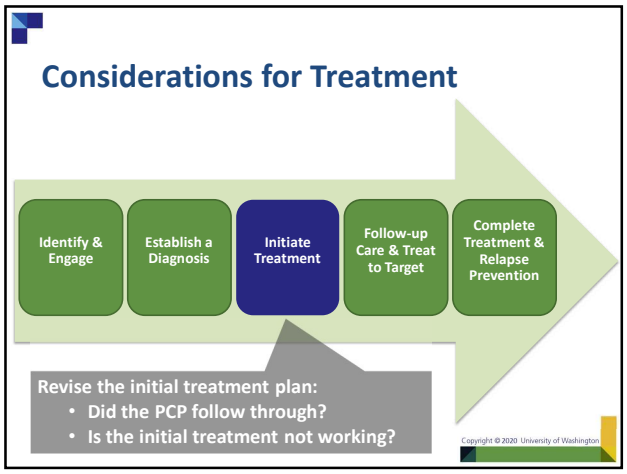
Considerations for Treatment
Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
Revise the initial treatment plan:
• Did the PCP follow through?
• Is the initial treatment not working?
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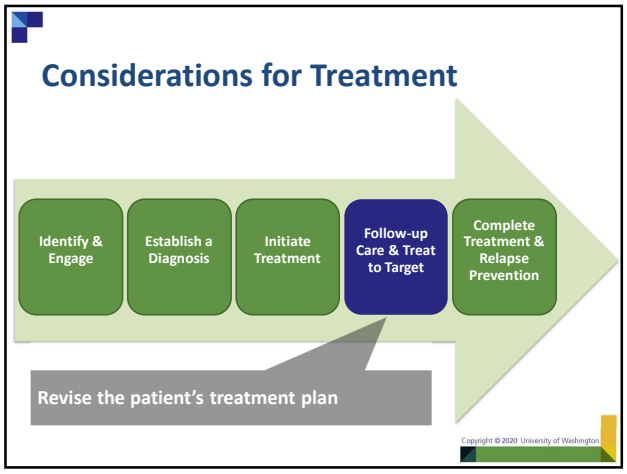
Considerations for Treatment
Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
Revise the patient's treatment plan
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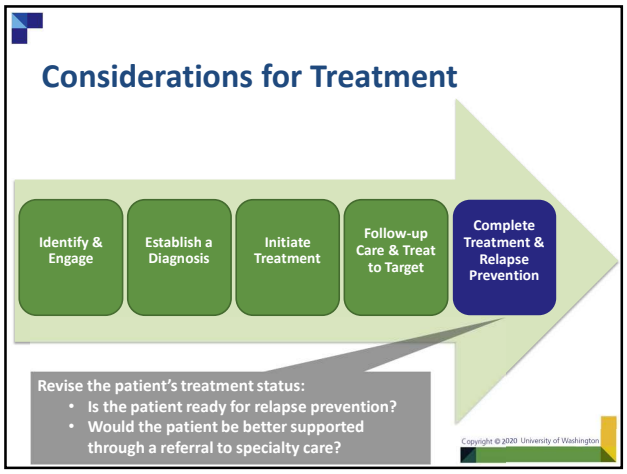
Considerations for Treatment
Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
Revise the patient's treatment status:
• Is the patient ready for relapse prevention?
• Would the patient be better supported through a referral to specialty care?
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Make a Laundry List of Treatment Enhancements

- **Engagement**
  - Enlist family support (with patient's consent)
  - Check for unstable social situations (food, housing)
  - Check for signs of stigma, shame
  - Increase frequency of contact
- **Treatment**
  - If medications aren't working, consider trying a behavioral intervention or vice versa
  - Remember the array of treatments available:
    - PST, CBT, Behavioral Activation, Medications

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Persistence Pays Off!

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PRACTICE

Example Case

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Case

- Vinnie is a 46-year-old plumber. He is a patient of Dr. Smith, who he has been seeing lately for hypertension and pre-diabetes.
- He was referred to the collaborative care team about 4 months ago after screening positive for depression on the PHQ-9.
- He was started on behavioral activation, and on fluoxetine 20mg, then 40mg as recommended by the psychiatric consultant.
- After 12 weeks, he has been seen 5 times, his PHQ-9 has gone up and down a little, but he is still at 16 – he had started at 18. He missed an appointment with the care manager, and was starting to feel that treatment was a waste of time.

Task

- If you were Vinnie's care manager, what are 3 things you might do to improve the effectiveness of his treatment?
  - Consider the areas of the workflow, like Engagement, Diagnosis or Treatment.

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Engagement Strategies

Identify & Engage | Establish a Diagnosis | Initiate Treatment | Follow-up Care & Treat to Target | Complete Treatment & Relapse Prevention

Enlist family:
Think about coordinating with family.

Increase contact:
Reach out to the patient to arrange more frequent contact, in-person or by phone.

Educate the patient:
Reassure him that most patients need some tweaks to their treatment before they recover. Because we know this, we are more likely to persist and get better.

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Diagnosis Strategies

Identify & Engage | Establish a Diagnosis | Initiate Treatment | Follow-up Care & Treat to Target | Complete Treatment & Relapse Prevention

Consider screening again:
Inquire about use of alcohol or other substances again. Consider if there may be previously undetected bipolar disorder.

Check for medical changes:
Talk to PCP/read chart to see whether anything new is going on medically.

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Initial Treatment Plan Strategies

Identify & Engage | Establish a Diagnosis | **Initiate Treatment** | Follow-up Care & Treat to Target | Complete Treatment & Relapse Prevention

Check on medications:
Did the most recent medication changes recommended by the psychiatric consultant actually happen?

Consider a different behavioral approach:
Consider trying problem-solving treatment.

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Follow-up & Treatment to Target Strategies

Identify & Engage | Establish a Diagnosis | Initiate Treatment | **Follow-up Care & Treat to Target** | Complete Treatment & Relapse Prevention

Change medications?
Discuss update of psychiatric medication with the psychiatric consultant.

Discreetly inquire about medication side effects:
Fluoxetine can cause sexual dysfunction and people can be embarrassed to bring this up. Your psychiatric consultant will ask about this, so it is important to be able to talk to the patient about it.

Ask the patient for his perspective:
Ask the patient if he knows anything that could be interfering with his getting better.

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Case Follow-up

- **Treatment intensification strategies**
  - CM engaged Vinnie's family to gain support
  - CM educated Vinnie on medication side effects; changed medication

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This concludes the module.

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Relapse Prevention and Completing Treatment

133

In This Module

- ✓Define relapse prevention
- ✓Purpose of relapse prevention
- ✓Timing the relapse prevention plan
- ✓Best practices for developing relapse prevention plan
- ✓Practice case

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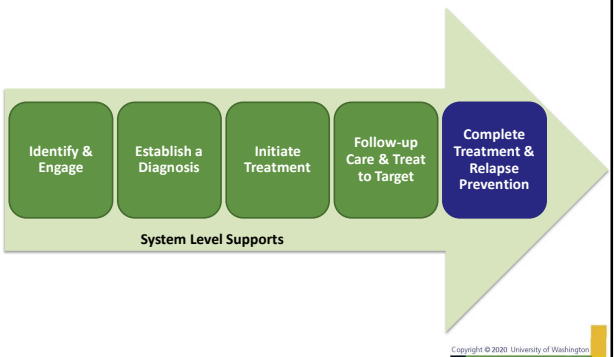
Collaborative Care Workflow



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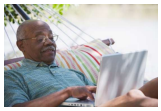
Defining Relapse Prevention

- Plan to empower patient in self-care after active care management is ended
  - Self-efficacy
  - Outcome expectancies
  - Coping

- Prevent recurrence of symptoms and/or help patient know when to seek help
  - Adherence to medications
  - Adherence to other interventions



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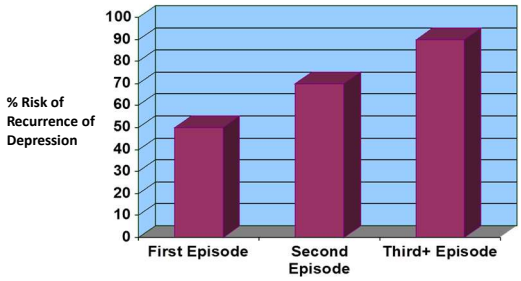
Depression Recurrence Is Common



Source: Judd LL et al., 2000; Mueller TI et al., 1999; American Psychiatric Association, 2000

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Ending Well Is Important: Purpose of Relapse Prevention

- Ending is about patient empowerment
  - Shift the focus from ending to celebrating
  - Info & tools to be in charge of care
- Core elements
  - Identify what worked to get better
    - Strategies to keep doing these things
  - Recognize symptoms of depression or anxiety
  - A plan if symptoms return

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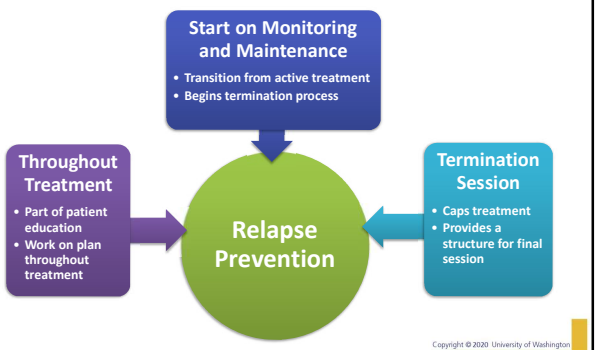
Timing the Relapse Prevention Plan



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Throughout Treatment

- Use PHQ-9 to monitor symptoms
- Support medication adherence (if part of treatment plan)
- Reinforce coping strategies (e.g. pleasant activities, behavioral activation, PST)
- Empower patient to actively participate in treatment monitoring

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Start on Maintenance & Monitoring

- Facilitate transition from active phase
  - Provide structure for step-down
  - Draft concrete plan together to try out
- Follow patient with monthly (brief) contacts
  - Usually by phone
  - Or in a maintenance group
- Finalize relapse prevention plan at termination

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Final Session

- Create concrete plan together for patient self-management
  - Self-care
  - Self-monitoring of symptoms
- Plan provides structure for final session
  - Helpful for both patient and provider
  - Reminds patient of progress made
- Plan provides tools for what to do if symptoms return
  - Mitigates fear of termination

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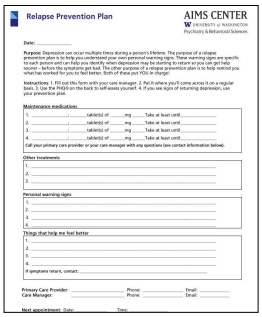
Relapse Prevention Plan


Relapse Prevention Plan

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- Maintenance medications and other treatments (behavioral therapy)
- Personal warning signs
- Plan for what to do if symptoms return

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Medications (If Part of Treatment)

- Discuss dose and length of time to stay on medications with PCP; reinforce with patient
- Review rationale for staying on medications and discussing any change with PCP before making a change
- Review how to handle refills, questions

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Other Treatments

- Talk therapy
- Behavioral activation
- Cognitive behavioral therapy
- Problem-solving treatment
- Support groups
- Positive habits

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Personal Warning Signs

- Ask patient to identify their personal signs/symptoms
- Review initial PHQ-9 or other behavioral health measures for symptoms
  - Especially if patient is having trouble remembering
- Help patient recall behaviors they had in the beginning of treatment
  - e.g., not getting dressed, not contacting friends

146

Healthy Behaviors: Things that Help Me Feel Better

- Review strategies that improved mood
  - Daily activities, social activities, pleasant activities
  - Exercise, sleep, routine activities
- Be detailed!

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Example Relapse Prevention Plan

- Medications and treatments
  - Prozac 20 mgs every am
    - Remain on the medications for at least 6 months
    - Call the pharmacy for refills and have them contact PCP if you run out of refills
    - Talk to your PCP before stopping
  - Continue attending AA meetings at the Cherry St Hall
- Warning signs of depression returning
  - Spending more time in bed, especially in the afternoon
  - Not returning friends' phone calls or turning down invitations
  - Low energy and lack of interest in getting out of the apartment
- Healthy behaviors
  - Walk 3 times a week with neighbor in the morning
  - Go to book club/read daily in afternoon
  - Deep breathing daily at 8 am

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Final Steps

- Contact information
  - Contact your PCP or *[your name and number]* if these symptoms persist and your healthy behaviors aren't enough
  - If you are having a crisis please call *[provide crisis line]*
- Review referrals (if any)
- Discuss follow up plan with their provider

149

Distributing the Plan

- Give copy to patient
  - Mail or hand it to patient
- Discuss plan for regularly reviewing relapse prevention plan
- Attach, scan or copy/paste into EHR for PCP
  - PCP needs to reinforce plan ongoing

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Care Manager's Checklist

- ❑ Explain why a relapse prevention plan is helpful
- ❑ Discuss these points:
  - ❑ Help patient watch for return of depression symptoms
  - ❑ Clarify how long to stay on medications (if used)
  - ❑ Outline helpful things to keep doing
- ❑ Discuss medications with patient (if patient is taking them)
- ❑ Review signs/signals that patient is feeling down or getting depressed
- ❑ Work with patient to make a list of behaviors that help improve mood
- ❑ Include contact information
- ❑ Ask patient to figure out when he/she will review this plan
- ❑ Explanation process
  - ❑ Ask patient if any questions
  - ❑ Use easy-to-understand language
  - ❑ Use approach that is empathetic and collaborative, not didactic

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PRACTICE

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Example Case

53-year-old male, presented with chief complaint of "not sleeping enough, having increased back pain, and feeling run down."

After four weeks in treatment, the patient's sleep was better and his energy improved, but his PHQ-9 score remained elevated at 14. The care manager notified the PCP and the patient's bupropion SR dose was increased to 150mg twice daily (morning and afternoon) as suggested by the psychiatric consultant. By week eight, the patient reported his concentration was improving at work, his back pain had improved, and his PHQ-9 score was down to 8. The patient continued on bupropion 150mg twice daily and ongoing follow-up with the care manager for behavioral activation.

At week 12, the patient's PHQ-9 dropped to a 4 and he reported that his pain was more manageable. The patient indicated that he had added to walking routine with his dog and twice-weekly aquarobics class at his local community center. He reported feeling better connected socially, and while he occasionally had bad pain days, he felt he had a plan to manage them well. The patient also reported a decrease in irritability, which resulted in better relationships with his family. The care manager recommended that the follow-up meetings be reduced to every other month.

After an additional four months, the patient's PHQ-9 score dropped to a 1 and he reported continued success in social engagement, even when his back bothered him. The patient and care manager began to discuss relapse prevention plans. He understood the need to remain on his antidepressant medication for a minimum of six months even though he was feeling better, but that he might consider a longer

- **What did this patient do to improve his mood?**
- **What treatments did he participate in that helped him to get better?**

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Example Case: You Try It!

- Three core elements to consider in relapse prevention planning:
  - Medications and behavioral treatments
  - Warning signs
  - Healthy activities
- What would you encourage the patient to consider including in the relapse prevention plan?

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Example Case: Relapse Prevention Plan

- Medications and behavioral treatments
  - Continuation of medications for one year
- Warning signs
  - Continue tracking symptoms on own with plan to monitor "hot" symptoms that indicate when to check-in with doctor:
    - If PHQ-9 is above 5 for two weeks
    - If experiencing unremitting pain for one week
    - If begin dropping activities
- Healthy activities
  - Continue pleasant activities (walking, swimming, socializing with family & friends, volunteering at local church on Sundays)
- How many of these elements did you include in your plan for this example case?

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This concludes the module.

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