

Treating Anxiety Within the Collaborative Care Model (Part 1)

Zachary Bodenweber, LMSW
Implementation Specialist
Collaborative Care Clinician
zbodenweber@outlook.com

Acknowledgements

- Virna Little, LCSW-R, SAP, PSYD
- Amy Jones-Renaud, MPH
- Rita Haverkamp, MSN, PMHCNS-BC, CNS
- Cynthia Kim, LCSW-R

AIMS CENTER
W UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

In reference to *Integrated Care: Creating Effective Mental and Primary Health Care Teams* by Anna Ratzliff, Jürgen Unützer, Wayne Katon, and Kari Stephens. University of Washington.

Content for this presentation was adapted from the presentation *Modular Anxiety Treatment* by:

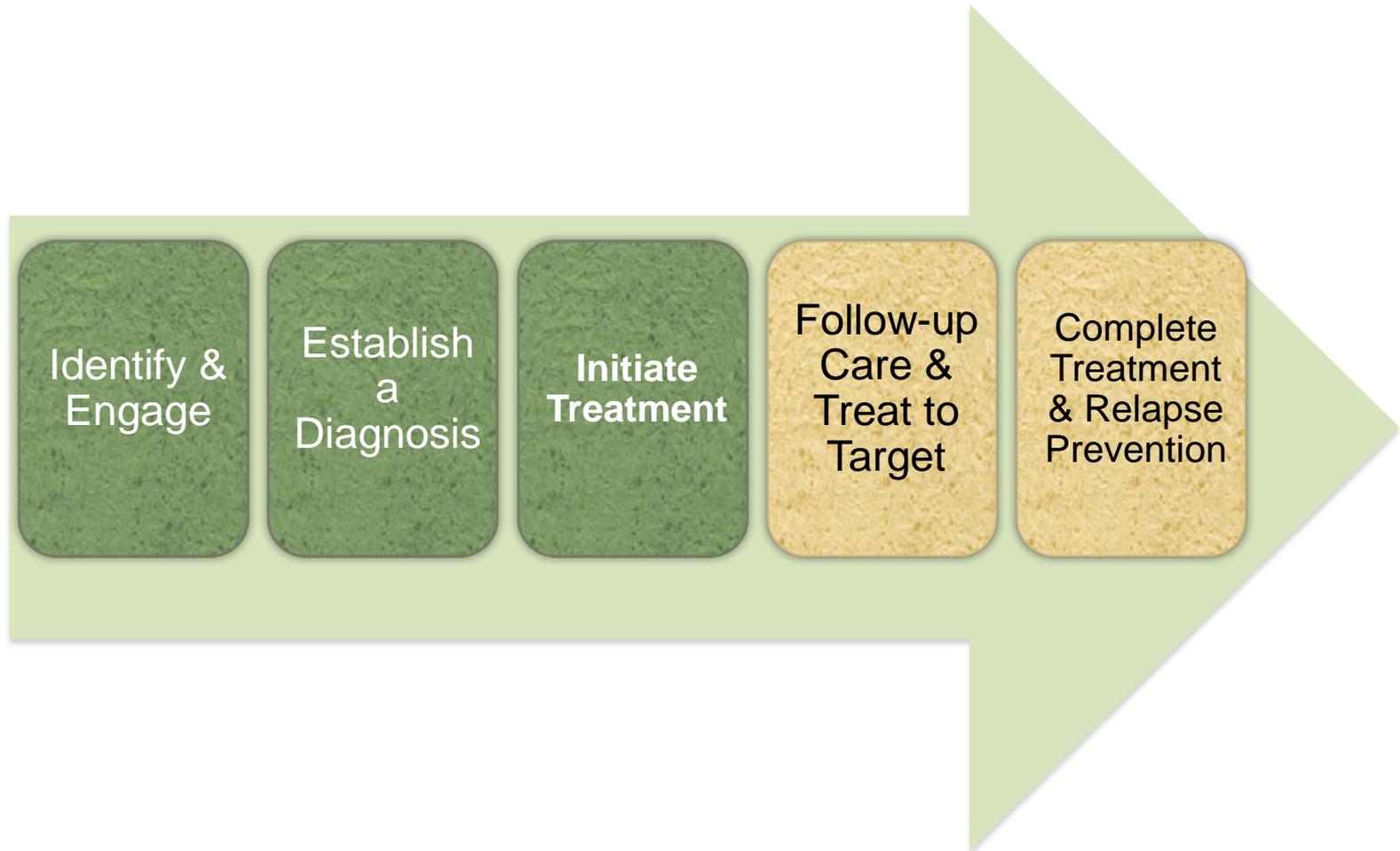
Stacy Shaw Welch, PhD
Anxiety & Stress Reduction Center of Seattle

Kari Stephens, PhD
University of Washington
Department of Psychiatry & Behavioral Sciences

We will learn about...

- 2018 Updates: Anxiety and CCMP
- Management and treatment of anxiety in Collaborative Care
 - Best Practices
 - Patient identification
 - Patient engagement
 - Psychoeducation
 - Treatment Options
- Assessment, diagnosis, and differential diagnosis

Care Manager Workflow



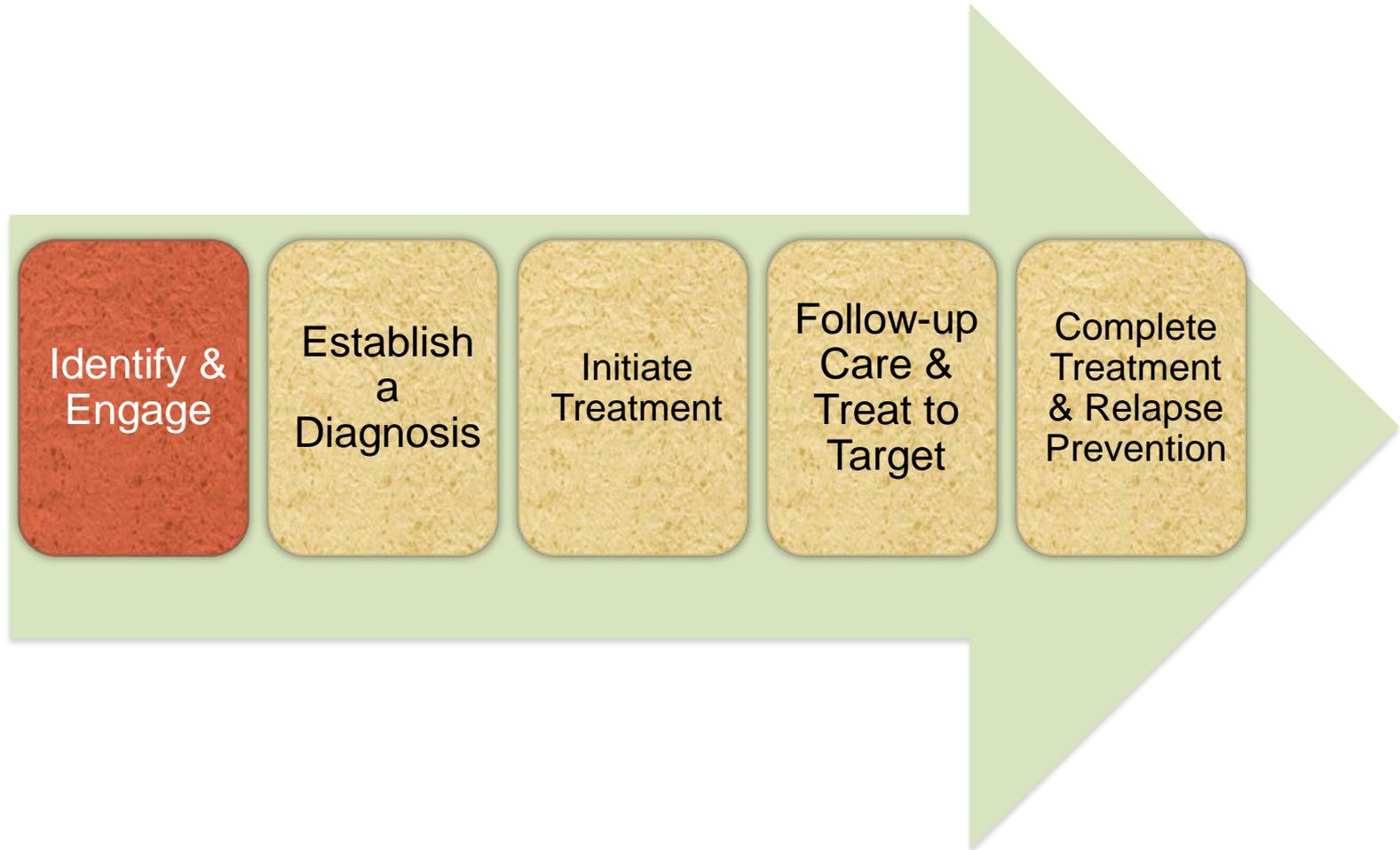
Collaborative Care Medicaid Program (CCMP)

- 2018 Updates added the following Anxiety diagnoses:
 - F41.9 - Unspecified Anxiety Disorder
 - F41.1 - Generalized Anxiety Disorder (GAD)
 - F41.3 - Other mixed anxiety disorders
 - F41.8 – Other specified anxiety disorders
- Routine Screenings with GAD-2 + GAD-7
- Tracked and monitored same as PHQ-9
 - Held to the same improvement standards

Clinical Impact of Anxiety

- Due to multitude of somatic symptoms, anxiety disorder complicate diagnosis and treatment, often leading to increased medical costs
- Highly Associated with impaired general health and psychosocial functioning
- Can worsen suicidal thinking and be a risk factor for suicide attempts

Identify + Engage



Working as a Team

- **PCP:** Recognize the signs of possible anxiety disorder(s), perform/review screening of symptoms (GAD-7), gather additional history, consider potential medical causes, educate, coordinate with Care Manager
- **Care Manager:** Complete assessment of symptoms and functional impairment, safety plan (if indicated), provide psychoeducation, engage, discuss treatment options
- **Psychiatric Consultant:** Clarify, determine, and/or refine diagnosis. Request further information. Craft treatment recommendation.

1) Identify + Engage

Identify

- Screening
- Clinical Manifestations

Engage

- Warm hand-off
- The Pitch

Identify

- Screen
 - GAD-2 + GAD-7
 - Reliable and valid for Generalized Anxiety Disorder screening in primary care
 - Both count toward Anxiety screening rate

GAD-2

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3

If positive, administer GAD-7

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

FOR OFFICE CODING: TOTAL SCORE 0 + _____ + _____ + _____

=Total Score: _____

Identify

- GAD-7 Score ≥ 10
- Persistent and excessive worrying
 - Distinguished in GAD by having greater worry over minor matters
- Other clinical manifestations:
 - Hyperarousal
 - Autonomic hyperactivity
 - Motor tension
 - Poor Sleep
 - Fatigue
 - Difficulty relaxing
 - Headaches
 - Neck, shoulder, and back pain
 - Medically unexplained concerns
 - Frequent visits with health professionals

Engage

- Warm Hand-off
 - Introduce yourself
 - Gather information
- The Pitch
 - Educate + Inform
 - Discuss treatment options

Warm Handoff

- Introduce the collaborative care manager as a member of the primary care team
- A colleague who specializes in behavioral health treatment or treatment patients who are feeling _____ (“overwhelmed, stressed, sad, etc.”).
- Explain that the care manager works closely together with PCP to provide the best treatment possible for the patient’s symptoms

Gather Information

- Presenting symptoms/problems
- Stressors + Supports
- Substance use (current + historical)
- Treatment history
 - Current and past medications
 - Side effects
 - Past psychotherapy and/or psychiatric treatment
- Medical problems (current + historical)

Gain Understanding

When Does Anxiety Happen?

- What situations?
- When during the day?
- What are they thinking/doing?

What Does Anxiety Get in the Way Of?

- What can't they do because of anxiety?
- How does anxiety hold them back?
- What do they avoid?

Rapport Builders

- Reflective Listening
- Paraphrasing
- Summarizing
- Clarifying
- Empathizing
- Validating
- Understand and Appreciate

The Pitch

Part 1: Educate + Inform

- Provide Brief Psychoeducation
 - Anxiety
 - Emotional fear response to threat
 - Identify cues and contributing factors
 - Generate hope (realistic)
 - Identify treatment expectations
- Normalize
 - Reduce stigma + fault/blame/shame
 - We are wired for survival
 - The avoidance of pain is a powerful motivator
 - Learned behavior

Educate and Inform

- The goal is to demystify anxiety
- Explain the anxiety is a normal part of life
- Anxiety is a normal reaction that has become too intense or triggered at times it is not needed
 - “Car Alarm” or “Guard Dog”
- Anxiety disorders are the result of genetic factors, learned behavior, and habit
- Can be treated most effectively with a combination of behavioral approaches and medications

The Pitch

Part 2: Discuss Treatment Options

Things To Consider

- Level of Functioning
- Symptom Severity
- Patient Preference

Choose Modality

- Explain the process of each
- Set expectations
- Discuss pros and cons

Intervention Types

1. Talk Treatment or Individual Counseling
2. Medication Management
3. Watchful Waiting or Monthly Monitoring

Talk Tx or Medication? Both?

- CBT and Serotonergic Antidepressants
 - Best studied and most efficacious for GAD
- No head-to-head comparisons of CBT and serotonergic antidepressants
 - Meta-analyses have found equivalent effect
- For patients with significant impairment to functioning and symptom severity, medications may be needed as initial treatment before engagement and participation in talk treatment
- Robust evidence base supporting behavioral approaches for anxiety treatment
- Patient preference is a good start for most, but behavioral approaches should remain a priority

Patient Preference

- What is patient preference impacted by?
 - Beliefs associated with treatment
 - Medication and Talk Treatment
 - Past treatment experiences
 - Stigma/Bias
 - Family/peer treatment
 - Side effects
 - Time needed
- These concerns should be anticipated and addressed in discussion of treatment options

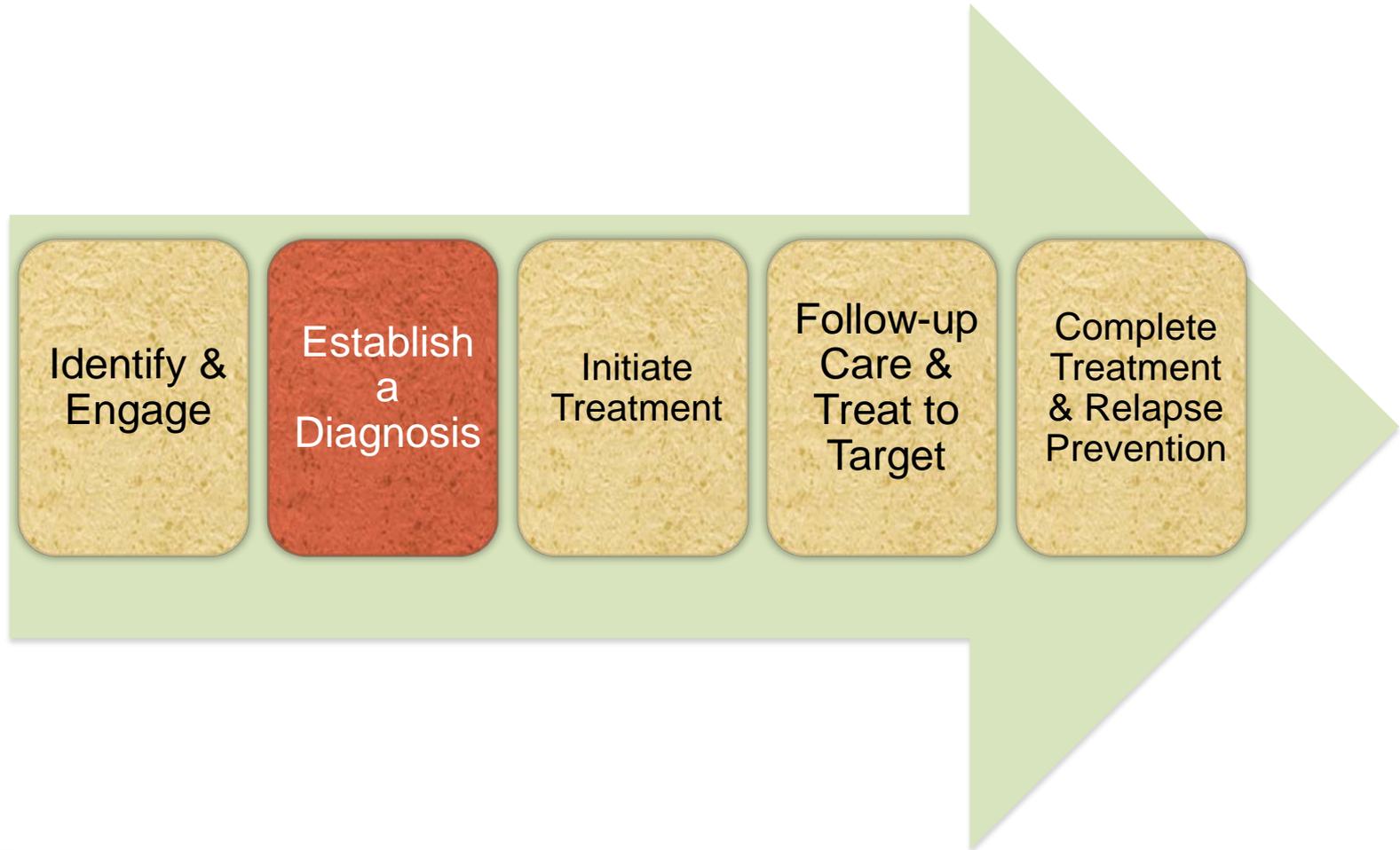
Watchful Waiting

- Patient's with more mild symptoms and no significant impairment to functioning may reasonably elect for forgo treatment initially
- Clinical follow-up is still important to monitor the course of the disorder and determine change to symptoms severity or impact
- This can occur in monthly contact with care manager, at which time GAD-7 is administered

Telephonic Encounters

- Include telephone use in discussion of treatment options
- Many patients (and clinicians) are not used to this treatment option
- Offers a flexible, patient-centered option that improves access + engagement
- CBT for Anxiety can be effectively delivered over the phone
- Set expectations
 - Duration
 - Frequency
 - Content
 - Date/Time

Establish a Diagnosis



2) Establish Diagnosis

- Understanding Anxiety
- Generalized Anxiety Disorder
 - Diagnostic Criteria
 - Differential Diagnoses
 - Comorbidity

Physiology

- **Parasympathetic Nervous System**
 - Rest + Digest
 - Green Zone
 - Conserves Energy
 - Slower heart rate
- **Sympathetic Nervous System**
 - Fight-or-Flight
 - Red Zone
 - Accelerated Heart Rate
 - Widened Bronchial Passages
 - Increased muscle blood flow and tension
 - Increased perspiration and blood pressure

Stress

- The body's response to demand from the environment
- Stress can be good or bad
- Stress + Recovery = Growth
- Useful stress activates us, initiates action
- Bad stress occurs when situational demands exceed a person's coping resources

Effects of Stress on the Body + Health

	Short-term	Long-term
Heart Function	Increased heart rate, muscle contractions, increased blood pressure	Increased risk of heart attacks, hypertension, stroke
Blood Sugar	More energy	Increased risk for diabetes
Muscle Tension	Releases when stressor ends	Increased risk for headache, worsen injury and pain syndromes
GI System	Temporary discomfort	Increased risk for ulcers and painful stomach conditions, chronic diarrhea and constipation
Respiratory Function	Increased rate of breathing, isolated panic attack	Exacerbate existing respiratory issues, contribute to recurring panic attacks
Immune Function	Increase temporarily to fight of disease/infection	Decrease immune function over time, increase disease and infection
Mental Health	Temporary change in mood, anxiety , irritability	Contribute significantly to depression, anxiety/worry, irritability/anger
Health Behaviors	Temporary changes to health habits that are detrimental	Poor nutrition, poor exercise, sleep disturbance, poor self-care, social isolation/withdrawal, increased smoking/alcohol/drugs

Anxiety = Emotional Fear Response



Anxiety

- Fear response to perceived threat
 - Anticipatory
 - Possible
 - Universal experience
 - Reaction to various stimuli (some stronger than others)
- Fears are often learned through the construction of meaning:
 - Life Experience
 - Evolutionary Origin
- Everyone has a different threshold and different cues

Anxious Behavior

- Reframing "dysfunctional" behavior is a critical step toward empowerment for positive change.
- Even behavior that seems problematic and has negative consequences (e.g., substance use) needs to be thought of as an attempt to cope with and adapt to life stressors or even a biological predisposition/neurochemical problem
- Every behavior meets a need. To help someone change, we must understand what is driving their current behavior. Many times it's the learned relief of pain. It's protection.
- This is useful to remember in communicating with both the patient **and** the care team

Safety Behaviors: Feel Good Now, But Hurt Later

Anxious people often engage in a range of behaviors to make themselves feel safer when they cannot avoid anxious situations

These behaviors are attempts to *neutralize* feelings of anxiety

Although these behaviors can facilitate functioning, they also prevent recovery

Examples:

- Reassurance seeking
- Behavioral rituals
- Safety cues/objects
- Over-preparation

Initial Diagnosis

- PCP: evaluate potential medical causes/origins of anxious symptoms, order labs/tests as needed, coordinate with care manager, arrange for further assessment
- Care Manager: provide further assessment, communicate relevant/important information to PCP, screen for substance use, support patient on arranging follow-up, consult with psychiatric consultant
- Psychiatric Consultant: provides expert guidance on diagnosis as needed.

Rule-Out: Medical

- Cardiovascular: angina, arrhythmias, congestive heart failure, hypo/hypertension, myocardial infarction (MI)
- Gastrointestinal: GERD, IBS, malignancy
- Hematologic: anemia
- Endocrine: hyperandrenalism, hypo/hyperthyroidism, endocrine tumor
- Immunological: anaphylaxis, lupus, MS
- Metabolic: hyponatremia, hypocalcemia, hypoglycemia
- Neurological: encephalopathy, temporal lobe epilepsy, CNS tumor, TBI, vertigo
- Respiratory: asthma, chronic obstructive pulmonary disease (COPD), pneumonia, pulmonary embolism (PE)

Rule-Out: Substances

- Withdrawal: alcohol, opiates, sedatives, hypnotics
- Intoxication: digitalis, anticholinergics, caffeine, hallucinogens, cannabis, stimulants (stimulant use, caffeine overuse)
- Prescribed Medications: SSRIs and antipsychotics (both potential causing akathisia), bronchodilators, (e.g., theophylline, sympathomimetics), oral or inhaled steroids

Provisional Diagnosis

- Assess anxiety triggers for differential diagnoses:
 - GAD: thought, worry
 - Panic Disorder: physical sensations of panic “out of the blue”
 - Social Anxiety Disorder: social situations
 - PTSD: trauma reminders
 - OCD: obsessive, intrusive thoughts
- If substance use is ongoing, asking about symptoms when not using and the benefits of use

CCMP Diagnoses

- F41.9 - Unspecified Anxiety Disorder
- **F41.1 - Generalized Anxiety Disorder (GAD)**
- F41.3 - Other mixed anxiety disorders
- F41.8 – Other specified anxiety disorders

Generalized Anxiety Disorder

- GAD is one of the most common mental disorders in primary care settings and is associated with increased use of health services
- Lifetime prevalence in US of 5.1% to 11.9%
- Twice as common in women as it is in men
- Most report they have felt anxious and nervous for entire life
- Broad range of onset
- Chronic and fluctuating symptoms
- Associated with a significant degree of functional impairment

GAD

- Characterized by excessive and persistent worrying that is hard to control, causes significant distress or impairment, and occurs on most days
- Allocate extensive attentional resources to threatening stimuli
- Detect “threats” rapidly and effectively
- Misinterpret ambiguous information as threatening
- Intolerance of uncertainty
- Worrying serves a purpose (problem-solving or avoiding)
- Worrying about worrying

GAD Diagnostic Criteria

A) Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)

B) Individual finds it difficult to control the worry

C) Associated with three (or more) of following for more days than not

- Restlessness or feeling on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance

GAD Diagnostic Criteria

D) The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

E) The disturbance is not attributable to the physiological effects of a substance or another medical condition

F) To be continued...

Diagnostic Features

- Worry about multiple events or activities, mostly everyday, routine life circumstances
- Intensity, duration, and frequency of worry is out of proportion to the actual likelihood or impact of anticipated event
- Difficult to control the worry and to keep worrisome thoughts from interfering with attention to tasks at hand

Case Example

22yo single Caucasian female in college presents with feeling anxious for a few years. Her friends call her a “worry wart”. She worries about her grades, family at home, how she’ll pay her college loans when she graduates, how will she decide on a major, what will happen if she chooses the wrong major, the homeless population in her area, upcoming presidential elections, and her dog’s health to the point where she loses sleep and constantly has these problems on her mind. “If it isn’t one thing, it’s another. My mind can’t seem to relax.” She says that she can’t focus in class and her grades are slipping. For the past year she has had tension headaches and neck pain.

What distinguishes GAD worry?

- Excessive and interferes with psychosocial functioning
- More pervasive, pronounced, and distressing
- Longer duration
- Often occurs without precipitant stimuli
- Wider range of worry content (life circumstances)
- Accompanied with physical symptoms
- Reported subjective distress

Average Worry or GAD?

Susie loves her mother dearly. Usually, she lights up when her mother calls and looks forward to their plans together. However, Susie has been worried the last few days and her heart sinks when the phone rings. She hasn't been sleeping well and has not had much of an appetite. Last week, her mother told her about some concerning findings at her last doctor appointment. She is waiting to hear back the results.

Average Worry or GAD?

Meredith has been anxious for as long as she remembers. It used to be school. She would always worry about her test results and prepare excessively for exams. She proofread papers over and over to make sure there were no mistakes. She hoped that the anxiety would go away after school, but now she finds the same thing in his career. She often gets to work 45 minutes early so she is not late and she checks in with her boss excessively to make sure he is doing everything ok. Lately, she has big project that is due and she is beginning to call out sick. She feels fatigued and tense.

Average Worry or GAD

Brandon often worries about people being mad at him. When someone doesn't answer the phone or text back, he becomes very anxious and thinks about any way he might have offended them. He often replays conversations with coworkers in his head to make sure it went ok. If they didn't laugh at a joke of his, he will send an email to them with an unrelated question and he will find it difficult to concentrate until they respond. He constantly feels like he is making mistakes at work. He thinks he forgot to lock the drawer to his desk, where he has jolly ranchers, and he fears that if the maintenance man decides to have one he might choke and die and it will be all his fault. He often feels his heart racing and has shortness of breath.

Average Worry or GAD?

Priscilla typically gets a little worried about her finances. She works three jobs and doesn't have much time for her children, so she also is concerned about their upbringing, since they spend most of the time with her unemployed sister. She tries to plan for her future and have enough savings put away to feed her family in case she gets fired, but is often concerned about her children's recent behavioral problems since she is not around often. She keeps pressing on like she always has.

What about F?

F) The disturbance is not better explained by another mental disorder

- Because the majority of anxiety symptoms are not specific to GAD, it is important to rule out other anxiety disorders before making the diagnosis

GAD

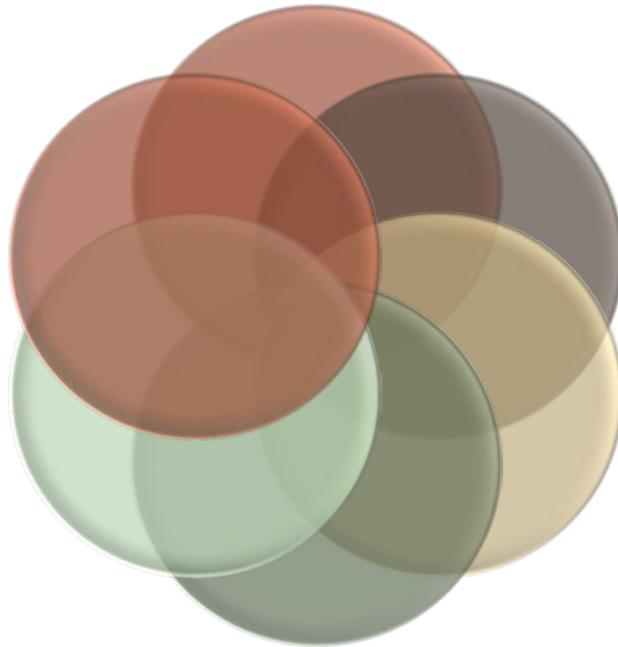
Phobias

OCD

Social
Anxiety

PTSD

Panic



Differential Diagnoses

- Anxious manifestations in other mental disorders
 - Worrying about...
 - Having panic attacks (Panic Disorder)
 - Negative evaluation (SAD)
 - Contamination or other obsessions (OCD)
 - Separation from attachment figures (Separation Anxiety)
 - Reminders of traumatic events (PTSD)
 - Gaining weight (Anorexia Nervosa)
 - Perceived appearance flaws (body dysmorphic)
 - Physical complaints (Somatic Symptom Disorder)
 - Delusional beliefs

Diagnostic Clarification

Have you had...?

- Worry, tension, or anxiety more days than not for 6 months (GAD)
- Recurrent intrusive recollections of trauma or avoidance of trauma reminders (PTSD)
- Anxiety and avoidance in social situations (SAD)
- Sudden and unexpected anxiety or physical symptoms when no one around (PD)

Differential Diagnoses

- Anxiety disorder due to another medical condition
- Substance/medication-induced anxiety disorder
- Social anxiety disorder
- Obsessive-compulsive disorder
- Posttraumatic stress disorder
- Adjustment Disorder (w/i 3 months of identifiable stressor)
- Depressive, bipolar, and psychotic disorders
 - Anxiety/worry is a common associated feature and should not be diagnosed separately if it has only occurred during course of these conditions

Panic Disorder

- Symptoms peak within 10 minutes and last up to 30-60 minutes
- Panic attacks occur out of the blue
- Persistent fear of having future panic attacks
- With or without agoraphobia
 - Avoidance of places and situations where an attack has occurred or may occur.

Panic Disorder

- Difficulty breathing and/or choking sensation
- Pounding heart or chest pain
- Intense feeling of terror, of losing control or are about to die
- Dizziness or feeling faint
- Trembling or shaking, tingling or numbness
- Chills, sweating, and/or hot flashes
- Nausea or stomachache, sudden urge to defecate

Obsessive Compulsive Disorder

- Obsessions

- Persistent & intrusive thoughts, feelings, images, impulses
- Recognized as product of own mind
- Causes marked distress

- Compulsions

- Repetitive, ritualized, or stereotyped physical or mental actions
- Done to relieve anxiety
- “prevents” some future event
- Satisfies a rigid rule
- Time consuming (>1 hour) or significant interference with normal routine

OCD Case Example

15 yo male is brought to the clinic by his mother because he is missing school and his grades have dropped. The pt reports that it's hard for him to leave the house in the morning. Mother reports that he is driving her nuts because he won't walk through the doorways in the house and mumbles something to himself each time he tries to walk through a doorway. "It can take him 30 minutes just to get from his bedroom to the living room, forget trying to get out the front door". He reveals that he also has to use paper towels to touch door handles and food products. "I know that sounds stupid, but I just have to". Mother says she is afraid her son is psychotic with all the talking to himself.

PTSD

- The event involved actual or threatened death, serious injury, or assault
- Event causes powerful subjective responses
- Event causes intense fear, helplessness, or horror
- Trauma Exposure
- 38% of population is exposed to severe traumas and only 9% develop the disorder

PTSD

- Avoidance of activities, places, thoughts, feelings, or conversations related to the trauma
- Emotional numbing - Loss of interest, feeling detached from others, restricted emotions
- Re-experiencing the traumatic event
 - Intrusive thoughts
 - Flashbacks/Nightmares
 - Exaggerated reactions to triggers
- Increased autonomic arousal
 - Difficulty sleeping
 - Irritability or outbursts of anger
 - Difficulty concentrating
 - Hypervigilance
 - Exaggerated startle response

PTSD Case Example

32 yo female with a history of rape and sexual abuse growing up. She reports that getting involved in serious relationships is very difficult for her and she wants to start therapy to address this. Once in therapy she reveals a history of poor sleep, getting angry really easily at her friends and co-workers, feeling jumpy, having a hard time being intimate with her boyfriend and feeling like she doesn't connect with him. She says that she feels uncertain about her future and actually doesn't imagine she'll be someone who lives to be too old. She has occasional low mood. When asked specific details about her past abuse, she says that she can't remember what happened after the man grabbed her by the arm. At work she gets upset because she keeps picturing her uncle touching her. Sometimes if someone grabs her on the arm, she gets a sinking feeling in her stomach and feels her heart race.

Specific Phobia

- Marked and persistent fear that is excessive or unreasonable when exposed to object/situation or in anticipation of exposure
- Upon exposure, immediate anxiety (even a panic attack; in children may present as crying, tantrum, freezing, clinging)
- Person recognizes fear as excessive
- Avoid or endure with intense anxiety
- Impairment in some functioning or significant distress
- Specify type: animal, natural-environment, blood-injection, injury, other

Specific Phobia Case Example

Joe is a 55 year-old male. During the past year he was diagnosed with diabetes and requires insulin injections. As a child he passed out once when having his blood drawn. Since then he has avoided viewing or thinking about anything related to injections. He also had a panic attack when he had to walk by a blood donor clinic. He has been unable to manage his injections and has been unable to watch anyone give him the injections. He feels extremely anxious leading up to injection times, and sometimes takes over an hour to allow the injection. Joe is often exhausted and upset for hours after an injection and this has interfered with his ability to attend work and upkeep responsibilities. Sometimes he avoids injections altogether. This behavior is leading to many arguments with his wife and his doctor is very worried about his health.

Social Anxiety Disorder (Social Phobia)

- Marked and persistent fear of scrutiny and humiliation in social situations
- Exposure leads to significant anxiety (e.g., acute stress reactions and/or panic attacks)
- Individual recognizes fear and response as unreasonable (not children)

Social Phobia Activating Events

- Eating or drinking in front of others
- Writing or working in front of others
- Being the center of attention
- Interacting with people, including dating or going to parties, asking questions or giving reports in groups
- Using public toilets
- Talking on the telephone

Social Phobia Case Example

26 yo African American female currently in college. She presents to individual therapy due to poor grades in college. In HS she was a straight A student. Since starting college she has gotten C's or D's. "I have been skipping class because it is too stressful. One professor called on me in front of 50 students and I knew the answer but it freaked me out so much, I haven't been back" "I know this sounds stupid, but it's like I can't even cross the street right because I feel like people are watching me fidget and get nervous. They must think I am such an idiot" Pt reports she is also late on her rent and has been avoiding calling her landlord because "I'll sound stupid".

Anxiety + Depression

- Most anxiety in clinical care is mixed with depression
- Generalized Anxiety Disorder (GAD) is 35-50% comorbid with depression
- Untreated GAD is associated with high rates of medical comorbidity and medical care utilization
- Comorbid depression negatively impacts prognosis and often results in prolonged course and increased functional impairment
- Neurotransmitters involved are serotonin, norepinephrine, and GABA
- Common heritability. Same biological underpinnings.

Overlapping Symptoms



Interest	Agitation	Sleep	Restlessness	Worry
Appetite	Dysphoria	Fatigue	Tension	
Esteem		Concentration	Irritability	
Suicide				

Part 2!

April 17th 2018

2:30-4:00 PM EST

Questions?

zbodenweber@outlook.com