AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Transitioning Patients Out of Collaborative Care

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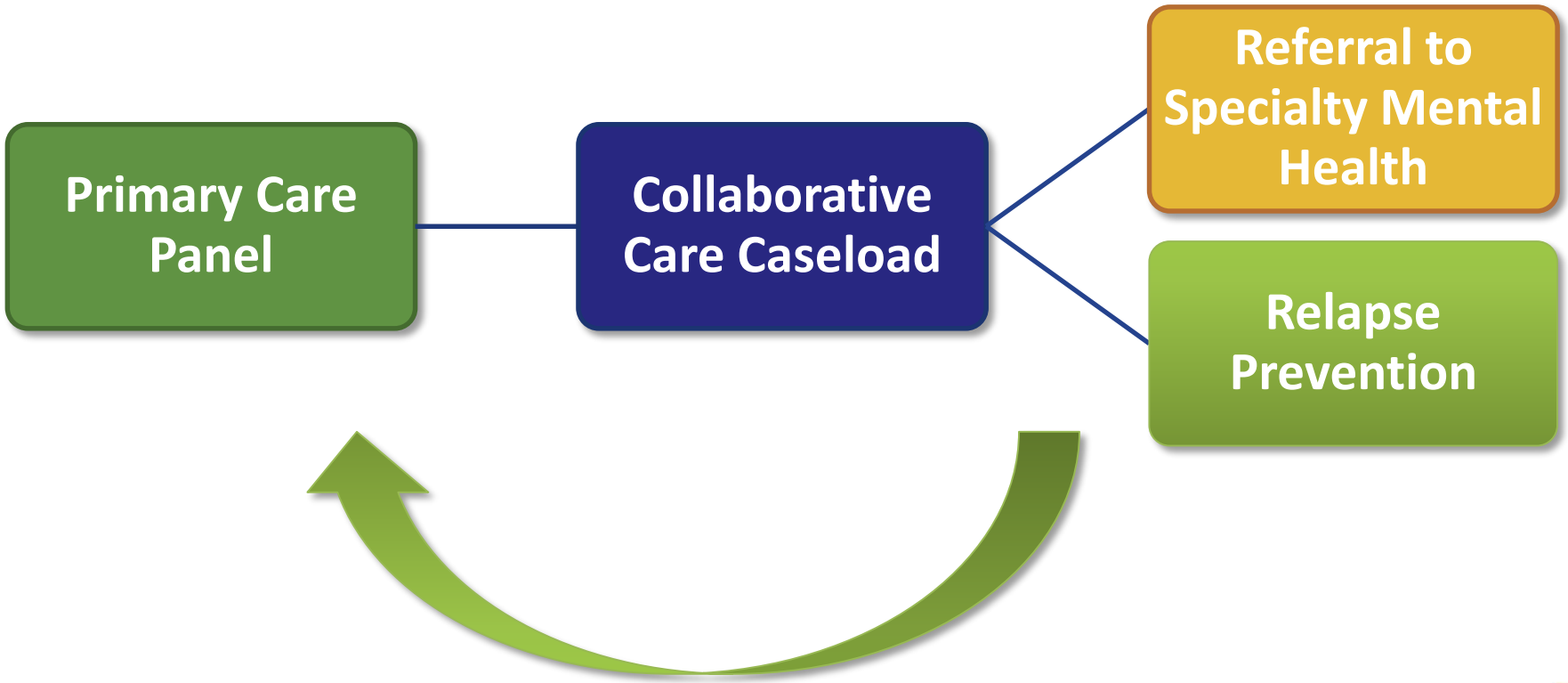
In this presentation:

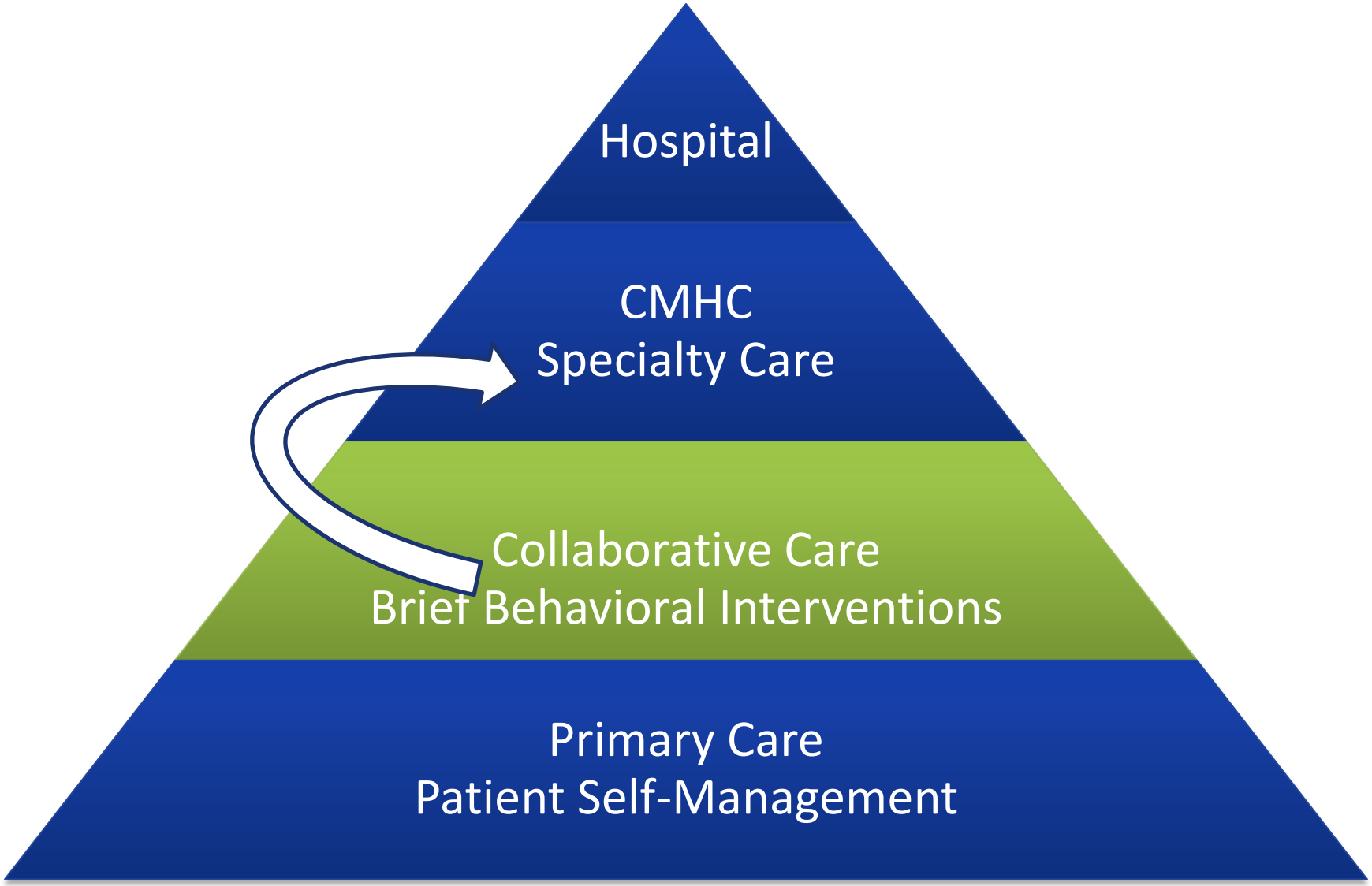
- ✓ Understanding when referral is necessary
- ✓ Making a successful referral
- ✓ Finding referral sources

Typical Course of Care Management: Duration



Reasons to refer

1. Patient not getting better
2. Conditions requiring special expertise
3. Conditions requiring longer-term care
4. Need for recovery-based services [people with serious and persistent mental illness]
5. Patient request



Patients who just aren't getting better

- **Not all patients will respond to treatment in collaborative care**
- **Know when to refer the patient to specialty care**
- **Lack of improvement is normal in all treatment settings**

Special expertise

- Trauma
- Substance use rehabilitation
- Major pediatric disorders
- Developmental Disorders
- Severe Obsessive-Compulsive Disorder
- Severe mood and bipolar disorders
- Serious and persistent mental illness

Patient request

- **Model not a good fit**
- **Desire in-person psychiatrist visits**
- **Interested in long-term therapy**

How to make a successful referral

- Not just a phone number
- Use relationship with known provider
- Call ahead to help set up connection
- Talk about what your ongoing role will be
- Follow up with referral
- Be realistic about payment / cost / insurance.
  - Sometimes treatment is worth it!

Develop a list of referral resources

- **How do you find them?**
  - Word of mouth
  - Colleagues
  - Professional listings – associations, etc
- **The phone is your friend**
  - Call potential sources of care and talk to them about how you could work together
- **Create a clinic list**
  - Make sure to develop a formal list that can be shared in the clinic to anticipate turnover

Lessons from our Practices

- **Eunice Kim, LMSW**
- **Zack Bodenweber, LMSW**

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Eunice Kim, LMSW

Implementation Specialist

Center for Innovation in Mental Health

Case Presentation: Bipolar Disorder

Case Presentation

Lorraine (mid-50s, black, heterosexual woman)

Presented with recurrent major depressive symptoms and anxious symptoms, financial stress, unemployed at enrollment due to chronic pain from previous back injury

Endorsed hypomanic symptoms at her initial visit when assessed but denied any previous behavioral health diagnoses

Lessons Learned

- **Anticipate bipolar depressive symptoms:**
  - **Assess for bipolar depressive symptoms at initial visit**
- **Provide psychoeducation:**
  - **Educate client on difference between unipolar and bipolar depressive symptoms and evidence-based treatments**
- **Manage client expectations:**
  - **Outline next steps if unipolar or bipolar depressive diagnosis confirmed**
- **Encourage self-monitoring of symptoms:**
  - **e.g., DBSA Tracker (free app)**

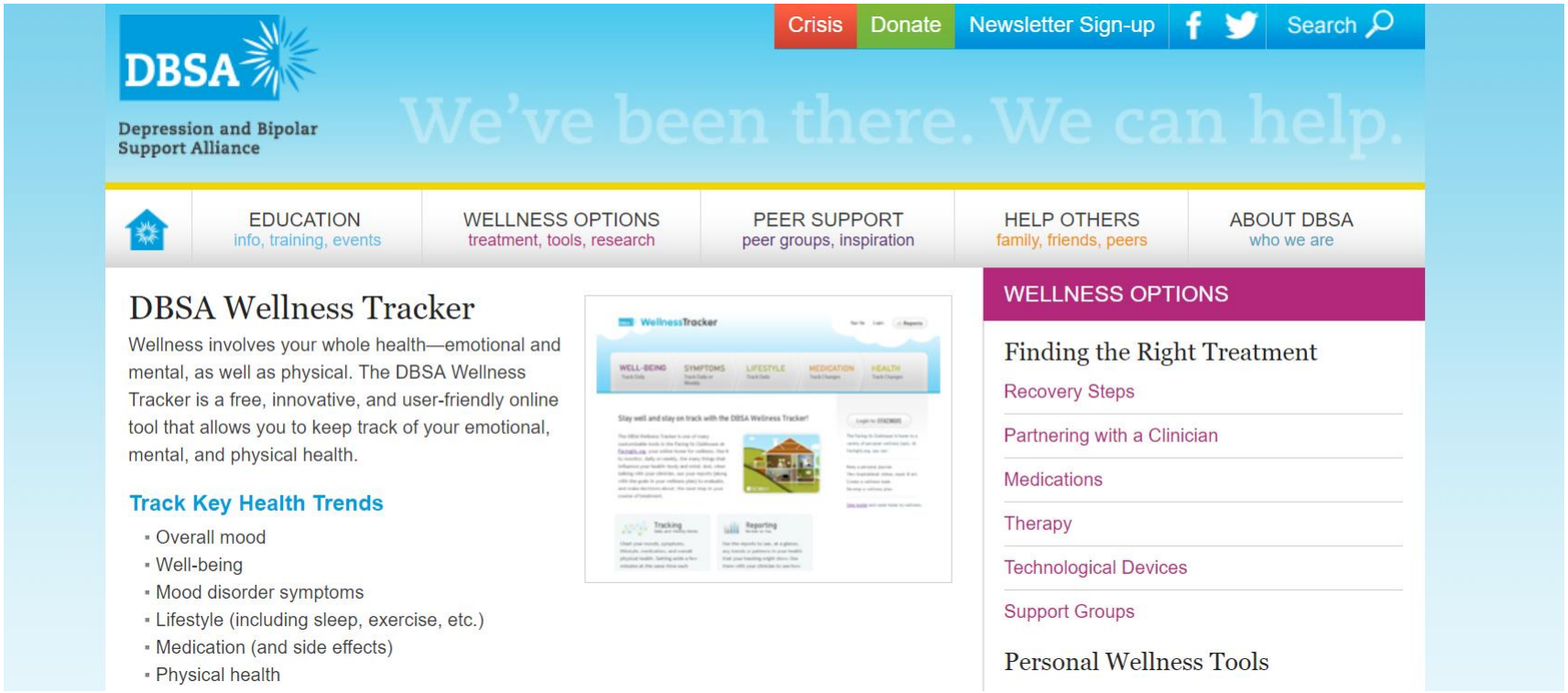
Initial Visit Workflow

- Review PHQ-9/GAD-7
- History of depressive/anxious and other behavioral health symptoms
  - including onset, duration, insight, triggers, coping skills/ resources
- History of previous treatment
  - E.g., medication, talk treatment
- Assess for bipolar depressive symptoms
- Explore family history for mental illness
- If eligible for Collaborative Care, introduce three treatment options

Lessons Learned

- **Anticipate bipolar depressive symptoms:**
  - **Assess for bipolar depressive symptoms in initial visit**
- **Provide psychoeducation:**
  - **Educate client on difference between unipolar and bipolar depressive symptoms and evidence-based treatment**
- **Manage client expectations:**
  - **Outline next steps and what will happen if unipolar or bipolar depressive diagnosis confirmed**
- **Encourage self-monitoring of symptoms:**
  - **e.g., DBSA Tracker (free app)**

Depression and Bipolar Support Alliance (DBSA) Wellness Tracker



Lessons Learned

- **Bridge to care:**
  - Schedule psychiatric evaluation
  - Consult with psychiatric provider/Psychiatric Consultant
  - Facilitate warm hand-off to referral source, whenever possible

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Transitioning Patients out of CoCM: Lessons Learned

Zachary Bodenweber, LMSW

Collaborative Care Clinician & Coach

Case Example: Selena

- 26 y.o., Jamaican American woman
- Presented with Anxiety and Depression
- Warm handoff, but initial hesitation to engage
- 6 months: Decrease in Depression, but not Anxiety
- Disclosure of past rape
- Referral to PTSD specialist

Lessons Learned

- **Language Use**
  - Not “higher”, but different
  - Destigmatize
- **Framing the Transition**
  - Specialist: a professional who specializes in treating your symptoms
  - Similar to other referrals from Primary Care
- **Reframing Patient Beliefs**
  - Not a failure or setback
  - Not “giving up”
  - Ensuring the best care possible

Case Example: Henry

- 62 y.o. man
- Major Depressive Disorder, recurrent
- Significant functional impairment
- Symptoms of psychosis later identified
- Minimal improvement after 3 months
- Referral to PROS (Personalized Recovery Oriented Services)

Lessons Learned

- **Leverage knowledge of community resources**
  - Make personal connections
- **Normalize**
  - "This has helped several of my patients"
- **Emulate warm handoff**
  - Call together
- **Close the loop**
  - Follow-up

Case Example: Jennifer

- 42 y.o. woman
- Presents after hospitalization
- Ongoing alcohol abuse, moderate depressive symptoms
- Enrolled to engage, but quick referral to substance use treatment program
- Re-enrolled in Collaborative Care after completion of treatment program

Lessons Learned

- **Build rapport**
  - Provide connection and hope
- **Facilitate behavioral change**
  - Motivational Interviewing
  - Reframing maladaptive beliefs
  - Problem-solve barriers
- **Set expectations**
  - What to expect
  - Back-up Plan
  - Open Door

Questions?