Resident Rotation: Collaborative Care Consultation Psychiatry

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Module 5:
Collaborative Care Consultation: Making Recommendations and Treating to Target
Learning Objectives: Module 5

By the end of this module, the participant will be able to:

• Make treatment recommendations for common primary care presentations.
• Assess a patient that has not responded to initial treatment plan.
• Apply a stepped-care approach to determine appropriate level of care.
Principles of Collaborative Care

- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care
- Accountable Care
Principle: Measurement-Based Treatment To Target

![Graph showing PHQ-9 scores over weeks in treatment.]

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# Caseload Summary: Prioritizing Cases to Review

<table>
<thead>
<tr>
<th>Patient</th>
<th>Caseload</th>
<th>Program</th>
<th>Tools</th>
<th>Logout</th>
<th>Search Patient:</th>
<th>Hello, Jerren (no user)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHITS ID</td>
<td>Population</td>
<td>Date Enrolled</td>
<td>Status</td>
<td>Date</td>
<td>PGQ - GAD - 7</td>
<td>ANX In Gr</td>
</tr>
</tbody>
</table>

- **Population**: U - Uninsured, V - Veterans, F - Veteran Family Members, H - Homeless, C - Children, O - Older Adults, I - CHW
- **L1**: Patient has been graduated to L1.
- **L2**: Patient is not to be taken by a Case Manager after 14 days.
- **Red**: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. OR if initial assessment is the only assessed score and is above 10.
- **Yellow**: Shows a 5 point improvement from the initial assessment score to the most recent score. OR most recent score is below 10.
- **Gr**: Shows a 10 point improvement from the initial assessment score to the most recent score. OR most recent score is below 10.
Principal: Evidence Based Care
STAR-D Summary

Level 1: Citalopram
~30% in remission

Level 2: Switch or Augmentation
~50% in remission

Level 3: Switch or Augmentation
~60% in remission

Level 4: Stop meds and start new
~70% in remission

Rush, 2007
Treatment Options

- Make 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
Recommendations: Medication Treatment

- Focus on evidence-based treatments and treatment algorithms
- Details about titrating and monitoring
- Brief medication instructions
Includes information such as:
- Basic education
- Names and doses of medication
- Common side effects
- Precautions
Example: Sertraline (Zoloft)

- **DOSING INFORMATION:** Week 1: Baseline weight. Consider BMP for baseline sodium in older adults. Start: 25 mg qday. Week 2: Increase to an Initial Target Dose of 50 mg qday, if tolerated. Week 4 and beyond: Consider further increases in dose if needed and tolerated, in 25 mg qday per week increments. Typical Dosage Range: 50-200 mg qday. Max Dose: 200 mg qday. Discontinuation: 25% per week to 25% per month depending on length of treatment in order to minimize withdrawal symptoms and relapse.

- **Monitoring:** Weight. Consider posttreatment BMP to rule out hyponatremia in older adults. OF NOTE: false-positive urine immunoassay screening tests for benzodiazepines have been reported in patients taking sertraline.

- **General Information:** Mechanism of Action: Selective serotonin reuptake inhibitor. FDA Indications: MDD, OCD, panic disorder, PTSD, social phobia, PMDD. Off-Label Indications: Other anxiety. Pharmacokinetics: T½ = 26 hrs. Common Side effects (MDD): Nausea (26%), diarrhea (18%), dry mouth (16%), insomnia (16%), somnolence (13%), dizziness (12%), tremor (11%), fatigue (11%), increased sweating, (8%), ejaculation failure (7%). Black Box Warning: Increased SI in patients < 25 y/o. Contraindications: Known hypersensitivity reaction to Zoloft. Use of a MAOI within 4 weeks of stopping Zoloft, concurrent use of a MAOI including drugs with significant MAOI activity (e.g., linezolid), or use of Zoloft within 4 weeks of stopping a MAOI. Concomitant use with pimozide. Warnings and Precautions: Clinical worsening and suicide risk, hypomanic/manic switch, serotonin symptoms, weight loss, seizure, discontinuation symptoms, abnormal bleeding, altered platelet function, hyponatremia, weak uricosuric effect, angle closure glaucoma. Metabolism/Pharmacogenomics: Metabolized by multiple P450 enzymes with 2C19 having the greatest pharmacogenetic and drug-drug interaction evidence. Use caution with 2C19 poor metabolizers. Significant drug-drug interactions: Weak 2D6 inhibitor. Use caution with drugs metabolized by 2D6 (e.g., TCAs); check all drug-drug interactions. Pregnancy: Category C. Breastfeeding: Compatible. Dosage Form: Oral solution, Tablet. Generic available: Yes. Cost: $. FDA label information from Drugs @FDA for Zoloft dated 2.1.2013.
SUMMARY: Pt is a 28yo male presenting with depression and anxiety. He has had an acute stressor related to job loss and relationship difficulties. Pt having trouble falling asleep (plays with laptop or phone in bed), sleeping 4-7 hrs/night.

Depressive symptoms: Moderate depression; PHQ-9: 18 Bipolar Screen: Positive screen; Appears more consistent with substance use Anxiety symptoms: Moderate to severe; GAD-7: 18 Past Treatment: Currently taking Bupropion and Citalopram (since 1/31) feels more in control, able to think before reacting, less irritable; Took sertraline, fluoxetine, bupropion at different times during teenage yrs: Doesn't recall effect Suicidality: Denies Psychotic symptoms: Denies Substance use: History of substance use/alcohol; Engaged in treatment currently Psychosocial factors: Completed court appointed time in clean and sober housing; Now living back with parents in Carnation; Attending community college; Continues to stay connected to clean and sober housing Other: ADHD: ASRS-v1.1 screening – positive; Not diagnosed as a child; Now getting B’s at community college

Medical Problems: hx of frequent migraines

Current medications: Bupropion HCl (Daily Dose: 450mg); Citalopram Hydrobromide (Daily Dose: 40mg)

Goals: Improve school functioning; Long term goal employment
ASSESSMENT: MDD (but cannot r/o bipolar disorder); Anxiety NOS; Alcohol use disorder, in early remission; r/o ADHD

RECOMMENDATIONS:
1) Continue to target sleep hygiene
2) Options for antidepressant augmentation. Engage patient in decision making about which ONE option to pursue:
   a. Option 1: Continue citalopram to 20mg as reported sedation on higher dose; Make sure he is taking dose at night and allow for longer period of observation to evaluate efficacy
   b. Option 2: Cross taper to fluoxetine; Week 1: Baseline weight. Consider BMP for baseline sodium in older adults. Start fluoxetine 10 mg qday. Continue citalopram 20mg. Week 2: Increase dose of fluoxetine to 20 mg qday, if tolerated, and stop citalopram. Week 4 and beyond: Consider further titration of fluoxetine in 10-20 mg qday increments. Typically need higher doses for anxiety. Typical target dosage: 20 mg qday
3) Continue close contact with care coordinator, supporting substance use treatment and behavioral activation.
4) Can consider strattera in the future if poor concentration persists; Would stay on 40 mg qday as combination with bupropion can increase drug level.
If patients do not improve, consider:

- Wrong diagnosis?
- Problems with treatment adherence?
- Insufficient dose / duration of treatment?
- Side effects?
- Other complicating factors?
  - psychosocial stressors / barriers
  - medical problems / medications
  - ‘psychological’ barriers
  - substance abuse
  - other psychiatric problems
- Initial treatment not effective?
A Different Kind of Treatment: Care Shaped Over Time

Traditional Consult

One Session = One Time Recommendation

Collaborative Care

Jan: Review 1 \(\rightarrow\) MDD and initiate treatment

Engaged with team but still symptomatic

Feb: Review 2 \(\rightarrow\) Adjust treatment

Engaged with team but persistent symptoms

Mar: Review 3 \(\rightarrow\) Intensify treatment
Typical Course of Care Management: Contact Frequency

- **Active Treatment**
  - Until patient has >50% decrease in symptoms and/or PHQ-9 score under 10
  - Minimum 2 contacts per month
    - Typical during first 3-6 months of treatment
    - Mix of phone and in-person works

- **Monitoring**
  - 1 contact per month
    - After 50% decrease in PHQ / GAD (or similar) achieved
    - Monitor for ~3 months to ensure patient stable
Typical Course of Care Management: Duration

- Primary Care Panel
- Collaborative Care Caseload
- Referral to Specialty Mental Health
- Relapse Prevention
Comparison of Contacts in Usual Care vs. IMPACT

Collaborative Care

- Green circle = PCP contact (avg. 3.5 contacts per year)
- Purple circle = Contacts with BHP/CM (avg. 10 contacts)
- Orange circle = Case reviews from psychiatric consultant to BHP/CM, PCP (avg. 2 case reviews)

50% - 70% treatment response/improvement

12 months
Recommendations: Other Interventions

Support managing difficult patients
- Working with demanding patients
- Protocols for managing suicidal ideation
- Working with patients with chronic pain

More recommendations “Beyond Medications”
- Behavioral Medicine and Brief Psychotherapy
- Referrals and Community Resources
- Disability
## Recommendations: Example Working with Difficult Patients

### Coaching PCP Skills:

**How to say no to a demanding patient.**

<table>
<thead>
<tr>
<th>Set your goals</th>
<th>Explore patient’s goals/concerns</th>
<th>Try Disarming Statements</th>
<th>Model calmness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recognize your own values and triggers</td>
<td>• “How had you hoped I could help you with this?”</td>
<td>• Actively helps pt make their point and calm down</td>
<td>• Lower your voice, move so they must turn in your direction</td>
</tr>
<tr>
<td>• Consider using a preplanned strategy for situations that you encounter often, i.e. narcotics/unnecessary tests</td>
<td>• Try to find underlying concerns</td>
<td>• “I see your point,”</td>
<td>• Encourage them to sit down--but let them control where to sit</td>
</tr>
<tr>
<td></td>
<td>• This may change a rant into a conversation</td>
<td>• “I understand,” “I agree”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “You’re right, you did have to wait a long time”</td>
<td></td>
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Supporting Care Team Members’ Work with Difficult Patients

Drawing upon psychotherapeutic understandings of patients to support the care team. Some examples:

- Observing interpersonal limits and boundaries in externalizing patients with dialectical balance between empathizing and understanding rationales for dysfunctional behaviors while promoting more adaptive ones.
- Recognizing patients’ difficulties trusting others and accepting help, or in contrast overvaluing self assertiveness and being independent – coaching care managers to recognize their characteristic responses to such interpersonal styles.
- Validating the importance and frequent difficulty of tolerating and responding empathically to negative emotions in patients.
- Helping set realistic expectations for patient outcomes for patients with complex and chronic problems; Shifting focus to appreciating the progress however small patients do make.
Reflection Questions

1) What experiences have you had making recommendations on consultation services? How is this similar and different to treating patients directly?

2) How do you keep current about evidence based treatments? How do you plan to do this in your career?

3) What are your experiences with brief behavioral interventions? What do you think will be challenging and rewarding in coaching care managers about these types of treatments?