AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

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

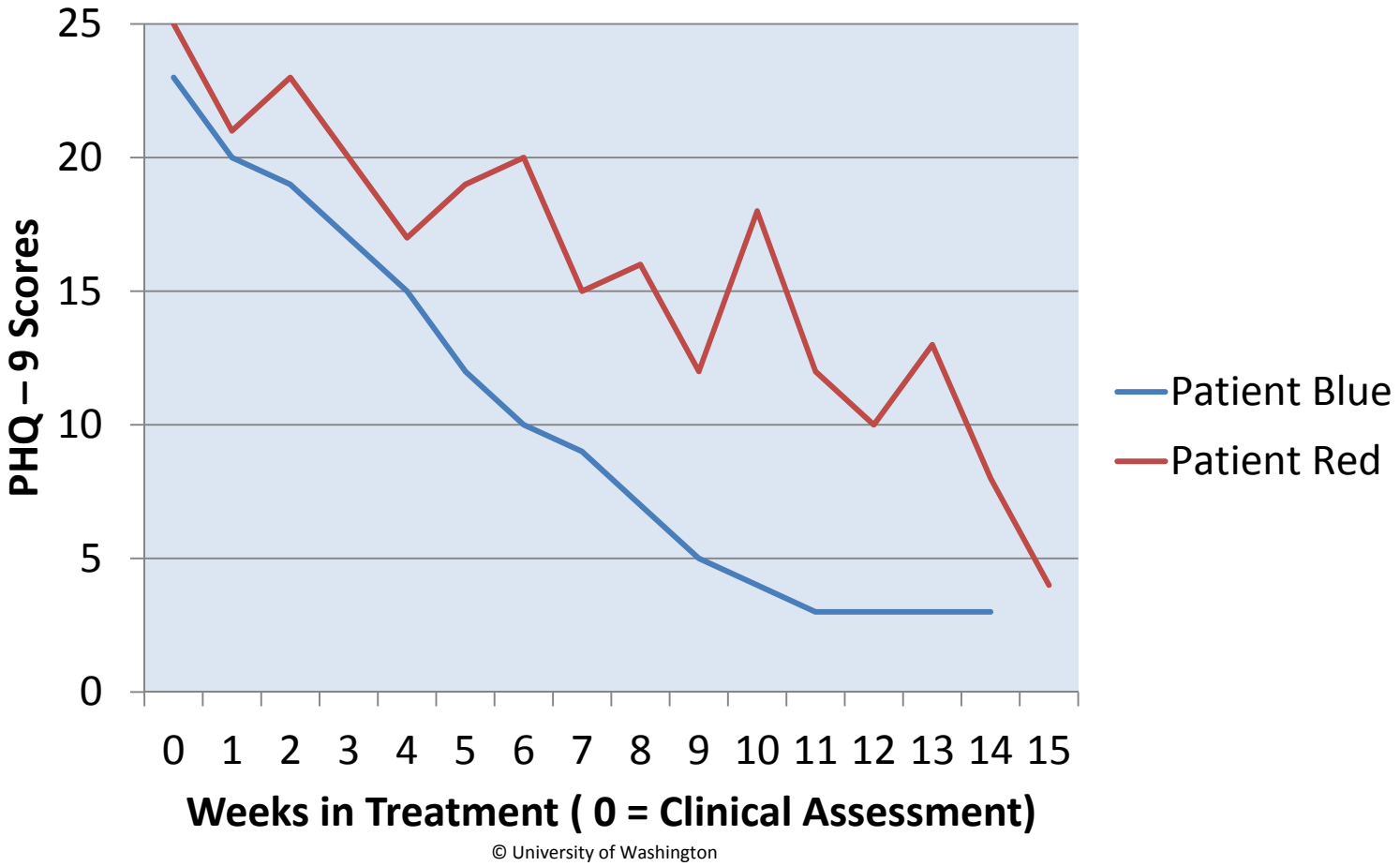
Measurement-Based Treatment to Target

Patient-Centered Collaboration

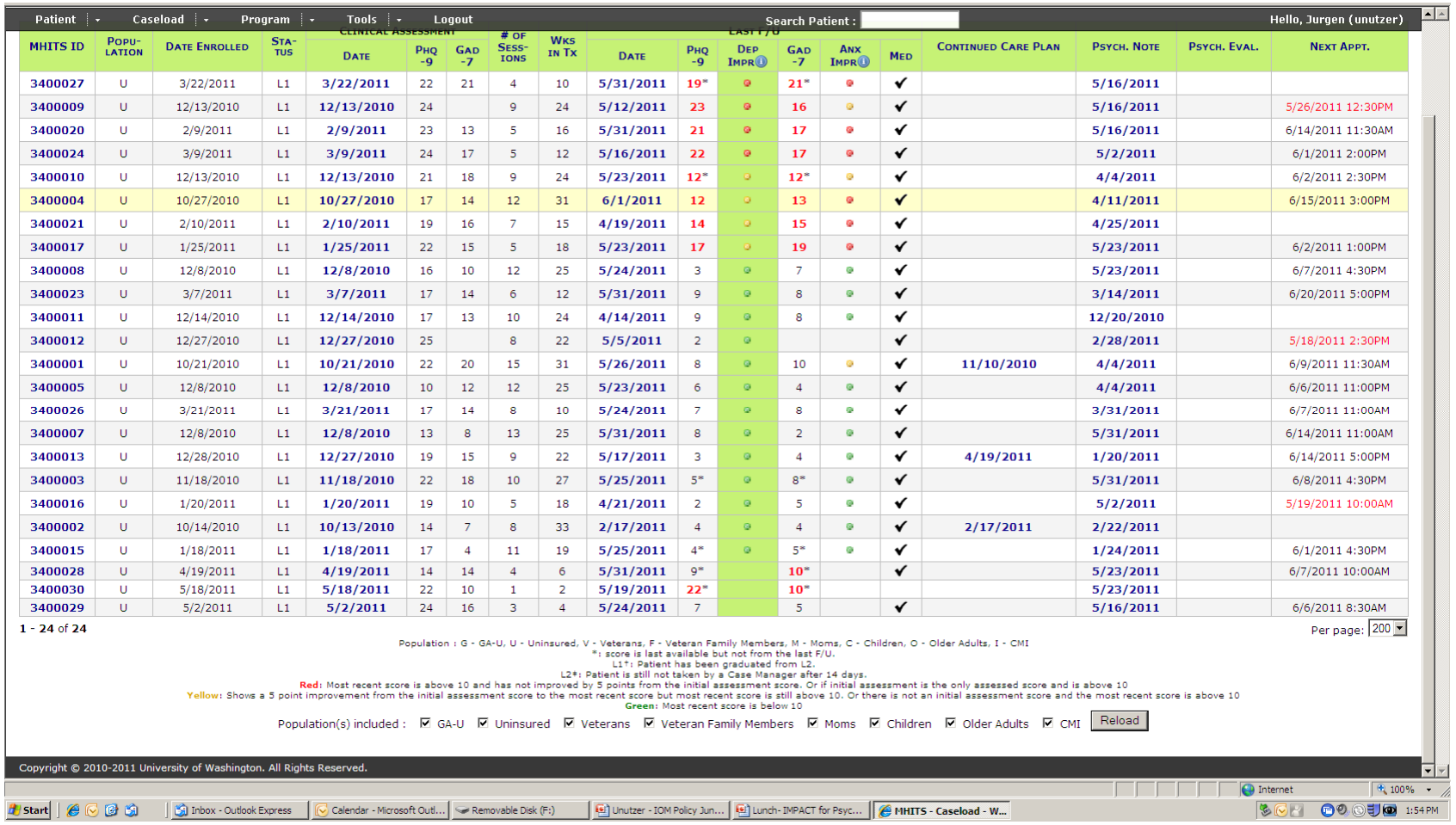
Evidence-Based Care

Accountable Care

Principle: Measurement-Based Treatment To Target



Caseload Summary: Prioritizing Cases to Review



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Per page: 200

Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1↑: Patient has been graduated from L2.
L2*: Patient is still not 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 but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

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

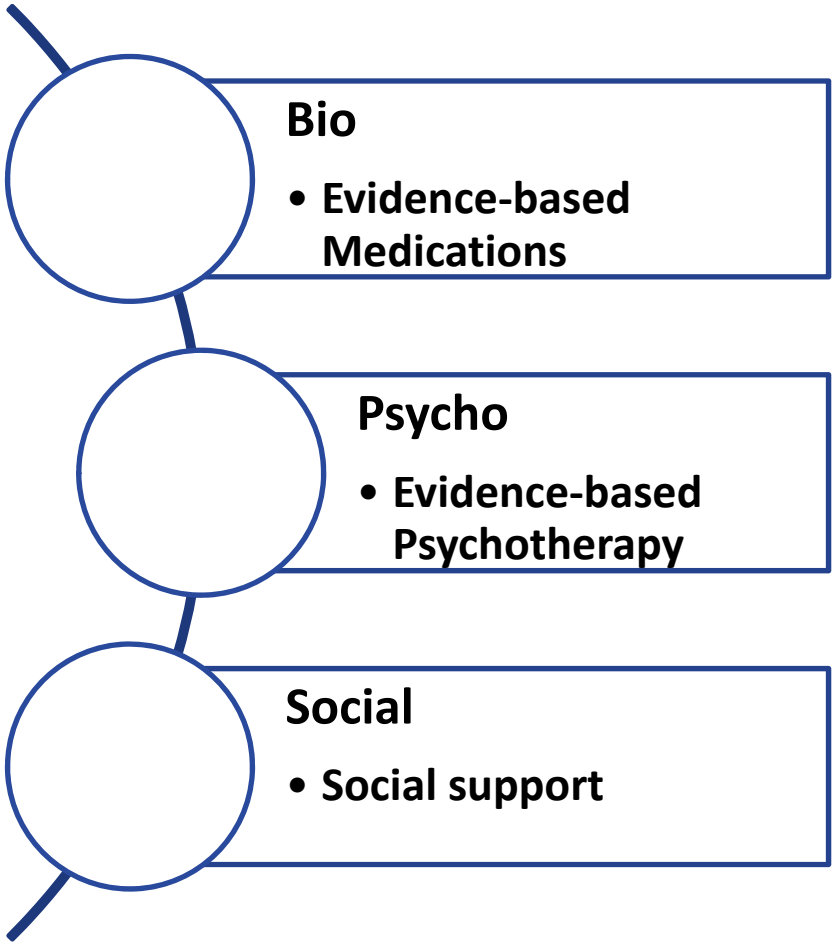
~60% in remission

Level 4: Stop meds and start new

~70% in remission

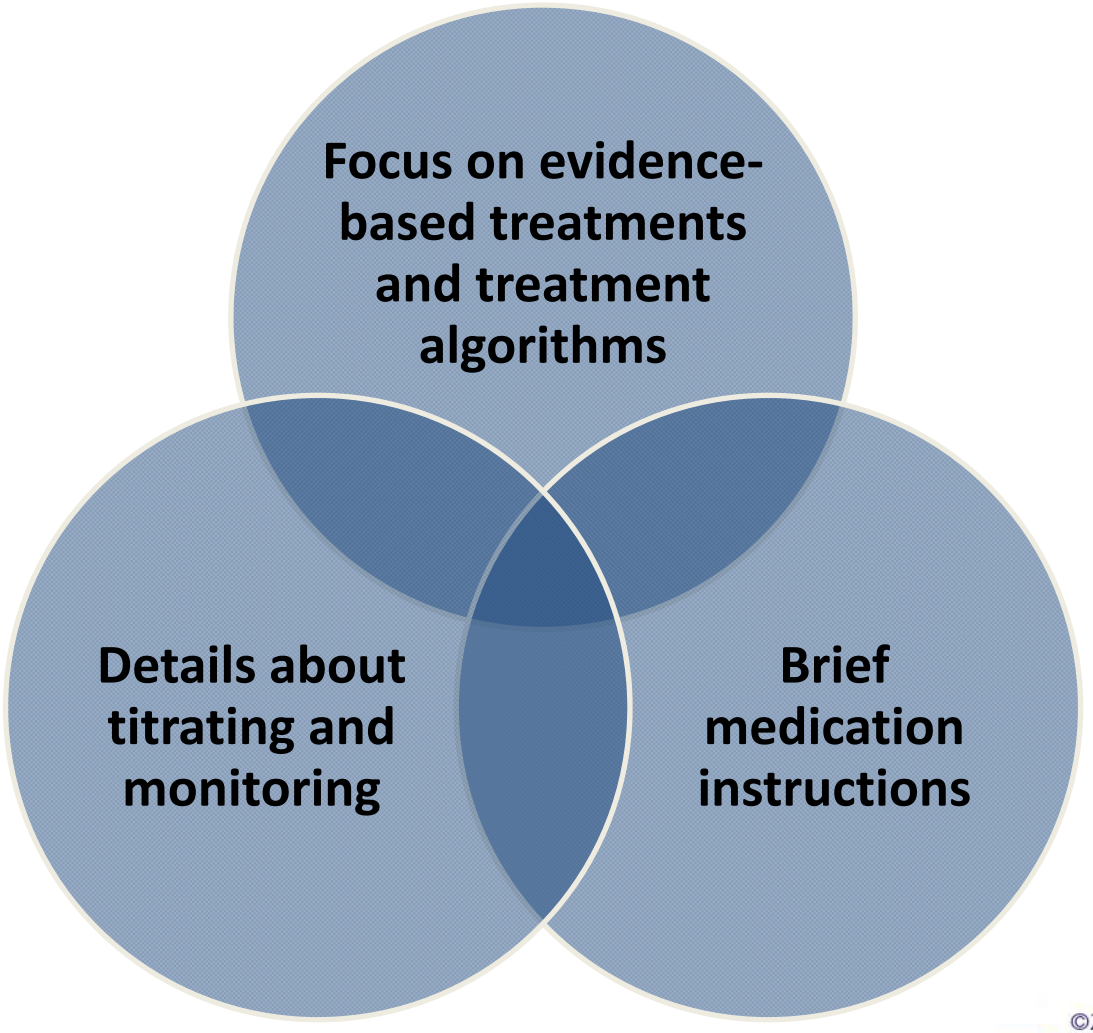
Rush, 2007

Treatment Options

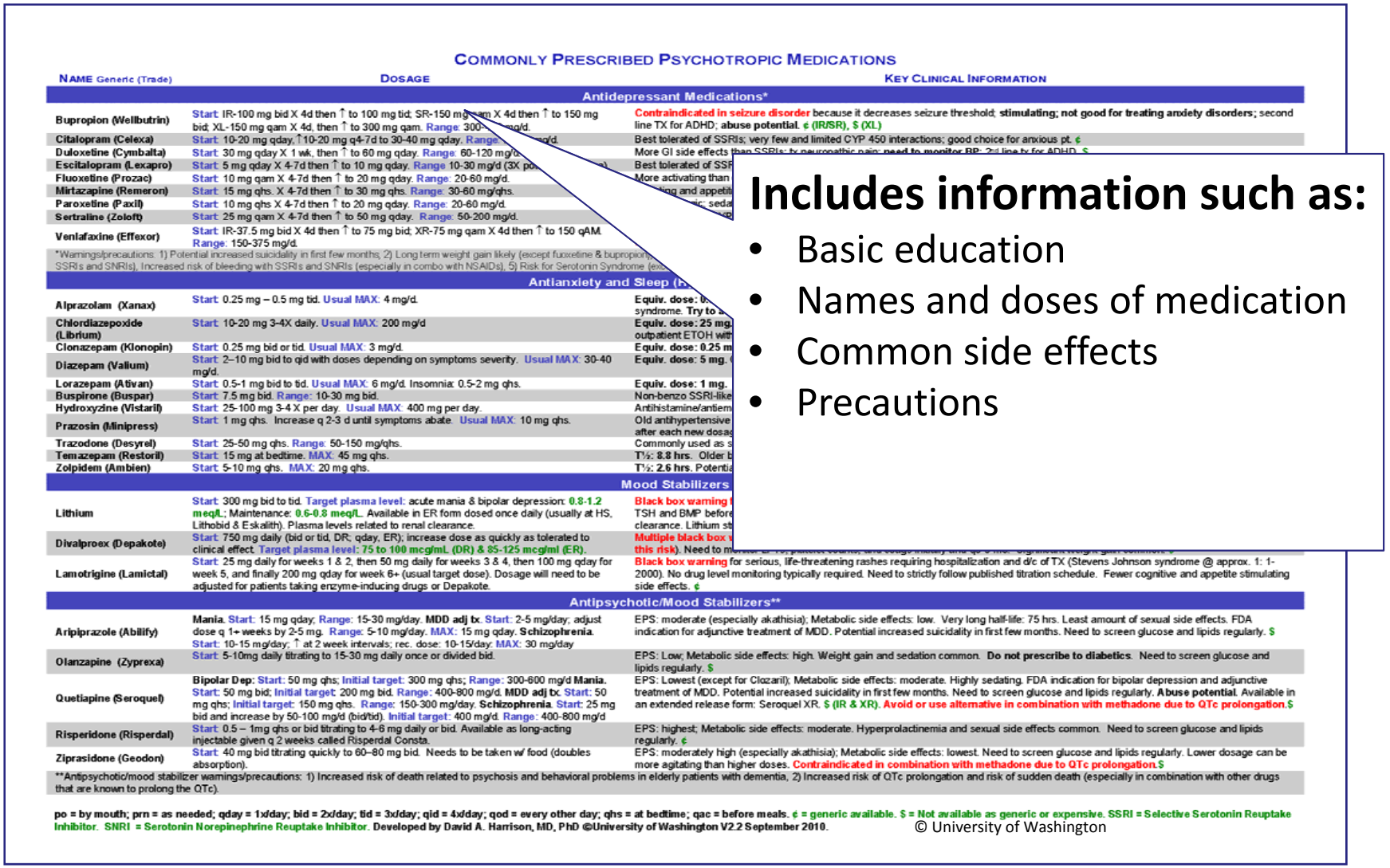


- Make BOTH medication and non-medication recommendations
- Supporting whole person treatment is important
- The treatment that WORKS is the best one
- Review all evidence-based treatment options available
- Discuss pros and cons of each option

Recommendations: Medication Treatment



Example: Prescribing Cheat Sheet



COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS

NAME Generic (Trade)	DOSAGE	KEY CLINICAL INFORMATION
Antidepressant Medications*		
Bupropion (Wellbutrin)	Start: IR-100 mg bid X 4d then ↑ to 100 mg tid; SR-150 mg qam X 4d then ↑ to 150 mg bid; XL-150 mg qam X 4d, then ↑ to 300 mg qam. Range: 300- mg/d.	Contraindicated in seizure disorder because it decreases seizure threshold; stimulating; not good for treating anxiety disorders; second line TX for ADHD; abuse potential. ¢ (IR/SR), $ (XL)
Citalopram (Celexa)	Start: 10-20 mg qday, ↑10-20 mg q4-7d to 30-40 mg qday. Range: mg/d.	Best tolerated of SSRIs; very few and limited CYP 450 interactions; good choice for anxious pt. ¢
Duloxetine (Cymbalta)	Start: 30 mg qday X 1 wk, then ↑ to 60 mg qday. Range: 60-120 mg/d	More GI side effects than SSRIs; tx neuropathic pain; need to monitor BP; 2nd line tx for ADHD. $
Escitalopram (Lexapro)	Start: 5 mg qday X 4-7d then ↑ to 10 mg qday. Range: 10-30 mg/d (3X po	Best tolerated of SSR
Fluoxetine (Prozac)	Start: 10 mg qam X 4-7d then ↑ to 20 mg qday. Range: 20-60 mg/d.	More activating than
Mirtazapine (Remeron)	Start: 15 mg qhs. X 4-7d then ↑ to 30 mg qhs. Range: 30-60 mg/qhs.	ling and appetit
Paroxetine (Paxil)	Start: 10 mg qhs X 4-7d then ↑ to 20 mg qday. Range: 20-60 mg/d.	ic; seda
Sertraline (Zoloft)	Start: 25 mg qam X 4-7d then ↑ to 50 mg qday. Range: 50-200 mg/d.	
Venlafaxine (Effexor)	Start: IR-37.5 mg bid X 4d then ↑ to 75 mg bid; XR-75 mg qam X 4d then ↑ to 150 qAM. Range: 150-375 mg/d.	
*Warnings/precautions: 1) Potential increased suicidality in first few months; 2) Long term weight gain likely (except fluoxetine & bupropion SSRIs and SNRIs), Increased risk of bleeding with SSRIs and SNRIs (especially in combo with NSAIDs), 5) Risk for Serotonin Syndrome (ex		
Antianxiety and Sleep (		
Alprazolam (Xanax)	Start: 0.25 mg – 0.5 mg tid. Usual MAX: 4 mg/d.	Equiv. dose: 0. syndrome. Try to a
Chlordiazepoxide (Librium)	Start: 10-20 mg 3-4X daily. Usual MAX: 200 mg/d	Equiv. dose: 25 mg. outpatient ETOH with
Clonazepam (Klonopin)	Start: 0.25 mg bid or tid. Usual MAX: 3 mg/d.	Equiv. dose: 0.25 m
Diazepam (Valium)	Start: 2–10 mg bid to qid with doses depending on symptoms severity. Usual MAX: 30-40 mg/d.	Equiv. dose: 5 mg. (
Lorazepam (Ativan)	Start: 0.5-1 mg bid to tid. Usual MAX: 6 mg/d. Insomnia: 0.5-2 mg qhs.	Equiv. dose: 1 mg.
Buspirone (Buspar)	Start: 7.5 mg bid. Range: 10-30 mg bid.	Non-benzo SSRI-like
Hydroxyzine (Vistaril)	Start: 25-100 mg 3-4 X per day. Usual MAX: 400 mg per day.	Antihistamine/antiem
Prazosin (Minipress)	Start: 1 mg qhs. Increase q 2-3 d until symptoms abate. Usual MAX: 10 mg qhs.	Old antihypertensive after each new dosa
Trazodone (Desyrel)	Start: 25-50 mg qhs. Range: 50-150 mg/qhs.	Commonly used as s
Temazepam (Restoril)	Start: 15 mg at bedtime. MAX: 45 mg qhs.	T½: 8.8 hrs. Older b
Zolpidem (Ambien)	Start: 5-10 mg qhs. MAX: 20 mg qhs.	T½: 2.6 hrs. Potenti
Mood Stabilizers		
Lithium	Start: 300 mg bid to tid. Target plasma level: acute mania & bipolar depression: 0.8-1.2 meq/L; Maintenance: 0.6-0.8 meq/L. Available in ER form dosed once daily (usually at HS, Lithobid & Eskalith). Plasma levels related to renal clearance.	Black box warning TSH and BMP before clearance. Lithium st
Divalproex (Depakote)	Start: 750 mg daily (bid or tid, DR; qday, ER); increase dose as quickly as tolerated to clinical effect. Target plasma level: 75 to 100 mcg/mL (DR) & 85-125 mcg/ml (ER).	Multiple black box v this risk). Need to m
Lamotrigine (Lamictal)	Start: 25 mg daily for weeks 1 & 2, then 50 mg daily for weeks 3 & 4, then 100 mg qday for week 5, and finally 200 mg qday for week 6+ (usual target dose). Dosage will need to be adjusted for patients taking enzyme-inducing drugs or Depakote.	Black box warning for serious, life-threatening rashes requiring hospitalization and d/c of TX (Stevens Johnson syndrome @ approx. 1: 1-2000). No drug level monitoring typically required. Need to strictly follow published titration schedule. Fewer cognitive and appetite stimulating side effects. ¢
Antipsychotic/Mood Stabilizers**		
Aripiprazole (Abilify)	Mania. Start: 15 mg qday; Range: 15-30 mg/day. MDD adj tx. Start: 2-5 mg/day; adjust dose q 1+ weeks by 2-5 mg. Range: 5-10 mg/day. MAX: 15 mg qday. Schizophrenia. Start: 10-15 mg/day; ↑ at 2 week intervals; rec. dose: 10-15/day. MAX: 30 mg/day	EPS: moderate (especially akathisia); Metabolic side effects: low. Very long half-life: 75 hrs. Least amount of sexual side effects. FDA indication for adjunctive treatment of MDD. Potential increased suicidality in first few months. Need to screen glucose and lipids regularly. $
Olanzapine (Zyprexa)	Start: 5-10mg daily titrating to 15-30 mg daily once or divided bid.	EPS: Low; Metabolic side effects: high. Weight gain and sedation common. Do not prescribe to diabetics. Need to screen glucose and lipids regularly. $
Quetiapine (Seroquel)	Bipolar Dep: Start: 50 mg qhs; Initial target: 300 mg qhs; Range: 300-600 mg/d Mania. Start: 50 mg bid; Initial target: 200 mg bid. Range: 400-800 mg/d. MDD adj tx. Start: 50 mg qhs; Initial target: 150 mg qhs. Range: 150-300 mg/day. Schizophrenia. Start: 25 mg bid and increase by 50-100 mg/d (bid/tid). Initial target: 400 mg/d. Range: 400-800 mg/d	EPS: Lowest (except for Clozaril); Metabolic side effects: moderate. Highly sedating. FDA indication for bipolar depression and adjunctive treatment of MDD. Potential increased suicidality in first few months. Need to screen glucose and lipids regularly. Abuse potential. Available in an extended release form: Seroquel XR. $ (IR & XR). Avoid or use alternative in combination with methadone due to QTc prolongation.$
Risperidone (Risperdal)	Start: 0.5 – 1mg qhs or bid titrating to 4-6 mg daily or bid. Available as long-acting injectable given q 2 weeks called Risperdal Consta.	EPS: highest; Metabolic side effects: moderate. Hyperprolactinemia and sexual side effects common. Need to screen glucose and lipids regularly. ¢
Ziprasidone (Geodon)	Start: 40 mg bid titrating quickly to 60–80 mg bid. Needs to be taken w/ food (doubles absorption).	EPS: moderately high (especially akathisia); Metabolic side effects: lowest. Need to screen glucose and lipids regularly. Lower dosage can be more agitating than higher doses. Contraindicated in combination with methadone due to QTc prolongation.$
**Antipsychotic/mood stabilizer warnings/precautions: 1) Increased risk of death related to psychosis and behavioral problems in elderly patients with dementia, 2) Increased risk of QTc prolongation and risk of sudden death (especially in combination with other drugs that are known to prolong the QTc).		

po = by mouth; prn = as needed; qday = 1x/day; bid = 2x/day; tid = 3x/day; qid = 4x/day; qod = every other day; qhs = at bedtime; qac = before meals. ¢ = generic available. $ = Not available as generic or expensive. SSRI = Selective Serotonin Reuptake Inhibitor. SNRI = Serotonin Norepinephrine Reuptake Inhibitor. Developed by David A. Harrison, MD, PhD ©University of Washington V2.2 September 2010.

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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.**

Making Effective Recommendations: Sample Case Review Note

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 straterra in the future if poor concentration persists; Would stay on 40 mg qday as combination with bupropion can increase drug level.

Caseload Consultation

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 → MDD and initiate treatment

Engaged with team but still symptomatic

Feb: Review 2 → Adjust treatment

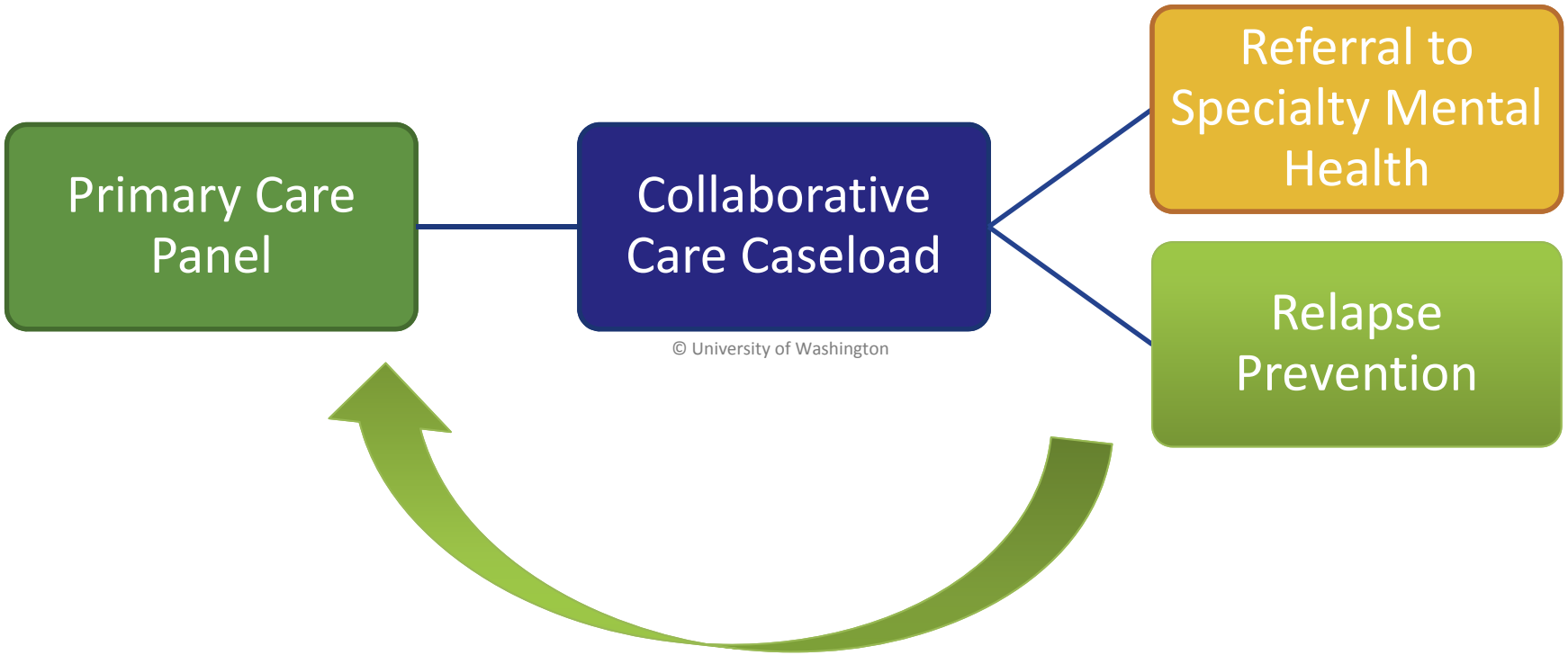
Engaged with team but persistent symptoms

Mar: Review 3 → 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



Comparison of Contacts in Usual Care vs. IMPACT

Collaborative Care

= PCP contact (avg. 3.5 contacts per year)

= Contacts with BHP/CM (avg. 10 contacts)

= Case reviews from psychiatric consultant to BHP/CM, PCP (avg. 2 case reviews)

0

12 months

50% - 70% treatment response/improvement

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.

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

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 mangers about these types of treatments?