PERSON 1:

Case 1:

You are a consulting psychiatrist to an FQHC. Listen to the case presentation by your BHP and provide consultation.

Would you make a diagnosis based on this information?
Would you change his medication from sertraline?
What, if any, additional information would you need before making a recommendation?
What behavioral interventions would you include in your plan?

Case 2:

You are the PCP. You call your psychiatric consultant for help regarding the following patient.

34 yo presenting with severe depression (PHQ 9:26) and anxiety (GAD-7:15) . He has been on sertraline 200mg and buproprion XL 300mg for longer than 8 weeks. He is now not leaving his home regularly and has increased SI with a vague plan related to overdose. He does not appear to meet criteria for hospitalization but I am worried about him. What do you think about antipsychotic?"

Case 3:

You are the consulting psychiatrist. You have received the following e-mail from a PCP. You call your BHP to discuss the patient during your regularly scheduled consult time.

Email from PCP:

"I have reviewed medication recommendations for TH and have concerns with the approach to starting him back on these meds since he was not stable on these meds when he was on them. He went to jail for a period of time and did not keep f/u appts critical to his physical health. In addition, when he first came to Washington, he was in a contentious relationship split with a partner. He reported he was sleeping 2-3 hours/night when taking 300 mg trazodone nightly and hydroxyzine and Benadryl. Feeling nervous a lot. Going through child support court. Out of work. "Major money problems." Since meeting him I've noticed some triangulation tendencies.

This doesn't seem like a simple depression to me. I'm interested in hearing other thoughts/ideas about diagnostic evaluation/treatments, because I don't think he was doing particularly well on the above treatment regimens. My biggest concern, is that he is bipolar, and that putting him on trazodone and other meds might worsen his symptoms. It is very difficult to assess effectiveness of any treatment due to his lack of follow-up and engagement in care. Maybe no medication treatment is safest here until he can demonstrate engagement in care?"

What recommendations do you make?
How do your bridge the difference in opinions between the two providers?

Case 4:

You are the PCP. You call the psychiatric consultant and leave the following message. The psychiatric consultant is only allowed to call back and either make recommendations or request a call back because they reach your voicemail when they call you back.

I have a patient is a 45 yo that just transferred to me from a psychiatrist. He has a diagnosis of bipolar I disorder. His last mania was many years ago and he has depression on and off. He is on Depakote 2000mg QHS, Lithium 1500mg QHS and Seroquel 400mg BID. He is feeling sedated. What do you think about Abilify instead of Seroquel? Oh, and he has elevated lipids. Thanks for any thoughts.

PERSON 2

Case1:

You are a BHP. Present the following case to the psychiatric consultant. You present a new patient to you during routine consultation.

We have a new patient who initially presented with depression and was started on sertraline 50mg. He now presents with history of recently eloping and traveling to Europe after dating his now wife for 1 month. He reports some decreased need for sleep and is presenting for extreme irritability including a recent physical fight with his wife. He reports heavy alcohol use.

Case 2:

You are the psychiatric consultant. One of your PCPs has paged you and presents a case.

Would you change his medications? What about an antipsychotic?
What, if any, additional information would you need before making a recommendation?
What behavioral interventions would you include in your plan?

Case 3:

You are the BHP on your weekly scheduled call with the psychiatric consultant. Discuss the following information with the psychiatric consultant.

You know the PCP is concerned about the patient having bipolar disorder. The patient has a negative CIDI-3. You have spoken with the patient' s previous psychiatrist of 10 years who has confirmed a diagnosis of MDD, never observed any signs of mania and agrees with patient assessment that was relatively stable on medications listed above. You share this information with the psychiatric consultant as well as the information the patient is requesting to have his old medication plan re-started.

Case 4:

You are the psychiatric consultant. You receive a message on your pager but when you call back you can only reach a voicemail. This is a PCP that you know and trust.

Would you make a recommendation?
Would you need to talk to the PCP before making any decisions?
What would you recommend?