Workshop: Working in Collaborative Care

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Principles in Action Case Example

Patient Centered Team Care / Collaborative Care

- Co-location is not Collaboration. Team members learn to work differently.

Population-Based Care

- All patients tracked in a registry: no one 'falls through the cracks'.

Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

- Treatments used are 'evidence-based'.

Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

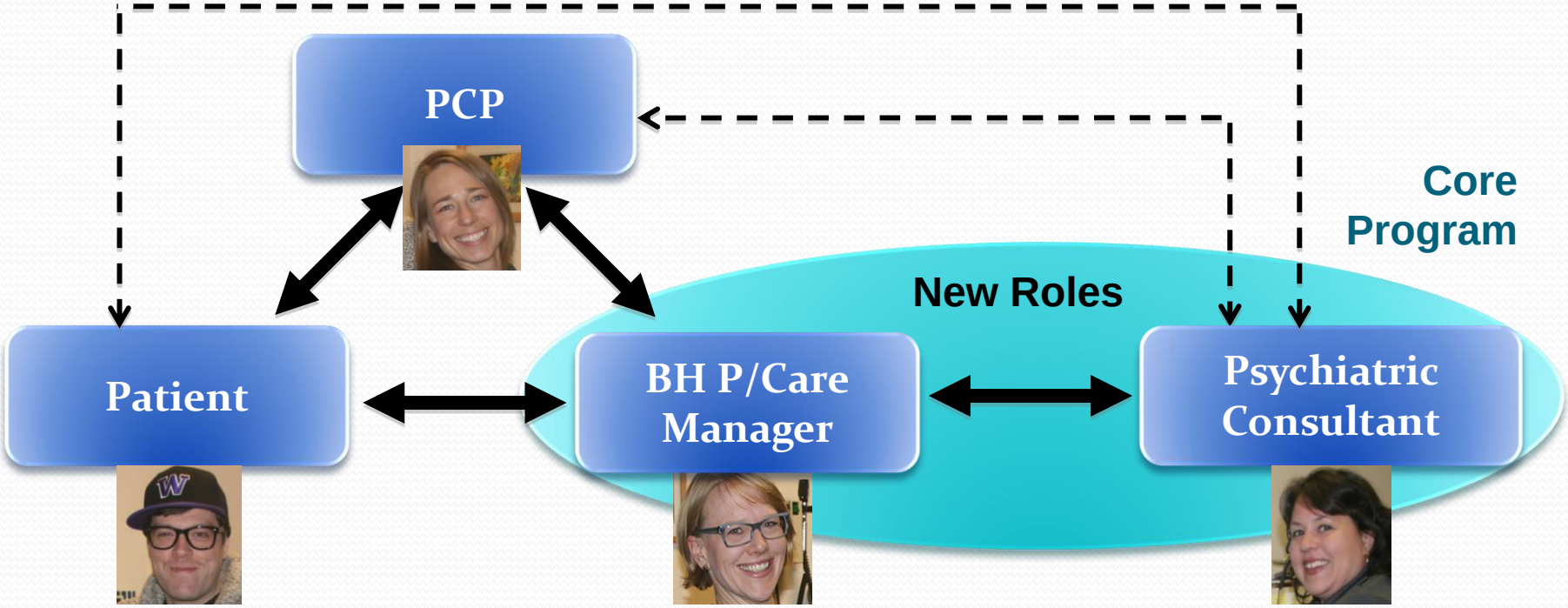
Daniel

http://aims.uw.edu/node/300

Daniel and Angel (PCP)

Principle 1:

Patient Centered Team Care



Daniel and Annie (BHP/CM)

Principle 2:
Population Based Treatment

Patient | Caseload | Program | Tools | Logout | Search Patient :

Current Patients

Flags	MHITS ID	Popu-lation	Enrollment Date	Sta-tus	Clinical Assessment			# of Sess-ions	Wks in Tx	Last Follow Up Contact				
					Date	PHQ -9	GAD -7			Date	PHQ -9	Dep Impr	GAD -7	Anx Impr
	000279	U	7/24/2012	L1	7/24/2012			2	32	7/24/2012	17			
	000258	F	6/18/2012	L1	3/18/2012	9		2	50	5/18/2012	17			
	000114	G	10/18/2010	L2R	1/18/2011	6		6	111	8/27/2012	17*			
	000156	S	1/25/2012	L1	11/25/2011		18	5	66	4/17/2012	17		14*	
	000245	V	6/14/2012	L1	7/15/2012			2	33	7/23/2012	14			
	000127	UV	5/1/2012	L1	6/14/2012	12	12	5	37	1/9/2013	13*		10	
	000218	G	4/3/2012	L1	4/6/2012			4	47	5/15/2012	12			
	000142	O	1/12/2012	L1	1/12/2012			2	59	2/27/2012	12			
	000277	U	6/8/2012	L1	6/8/2012	9		2	38	6/30/2012	10			
	000210	T	3/27/2012	L1	1/1/2012	25	19	9	61	6/13/2012	9		6	
	000216	U	12/30/2011	L1	11/29/2011	27		9	66	11/28/2012	9			
	000288	V	8/28/2012	L1C	8/16/2012	14		12	28	11/29/2012	6*			
	000232	V	11/16/2011	L1	3/1/2012	25	21	6	52	10/15/2012	5*		2*	
	000231	U	12/6/2011	L2G	1/10/2012	24	20	7	60	5/9/2012	5		5	
	000227	UP	4/3/2012	L1	5/18/2012			1	41					

Example: Structured Assessment

BHP/Care Manager is asked to briefly report on each of the following areas:

- Depressive symptoms
- Bipolar Screen
- Anxiety symptoms
- Psychotic symptoms
- Substance use
- Other (Cognitive, Eating Disorder, Personality traits):
- Past Treatment
- Safety/Suicidality
- Psychosocial factors
- Medical Problems
- Current medications
- Functional Impairments
- Goals

Screening Tools as "Vital Signs"

- Behavioral health screeners are like monitoring blood pressure!

- Identify that there is a problem
- Need further assessment to understand the cause of the "abnormality"
- Help with ongoing monitoring to measure response to treatment

Commonly Used Screeners

Mood Disorders

- PHQ-9: Depression
- MDQ: Bipolar disorder
- CIDI: Bipolar disorder

Anxiety Disorders

- GAD- 7: Anxiety, GAD
- PCL-C: PTSD
- OCD: Young-Brown
- Social Phobia: Mini social phobia

Psychotic Disorders

- Brief Psychiatric Rating Scale
- Positive and Negative Syndrome Scale

Substance Use Disorders

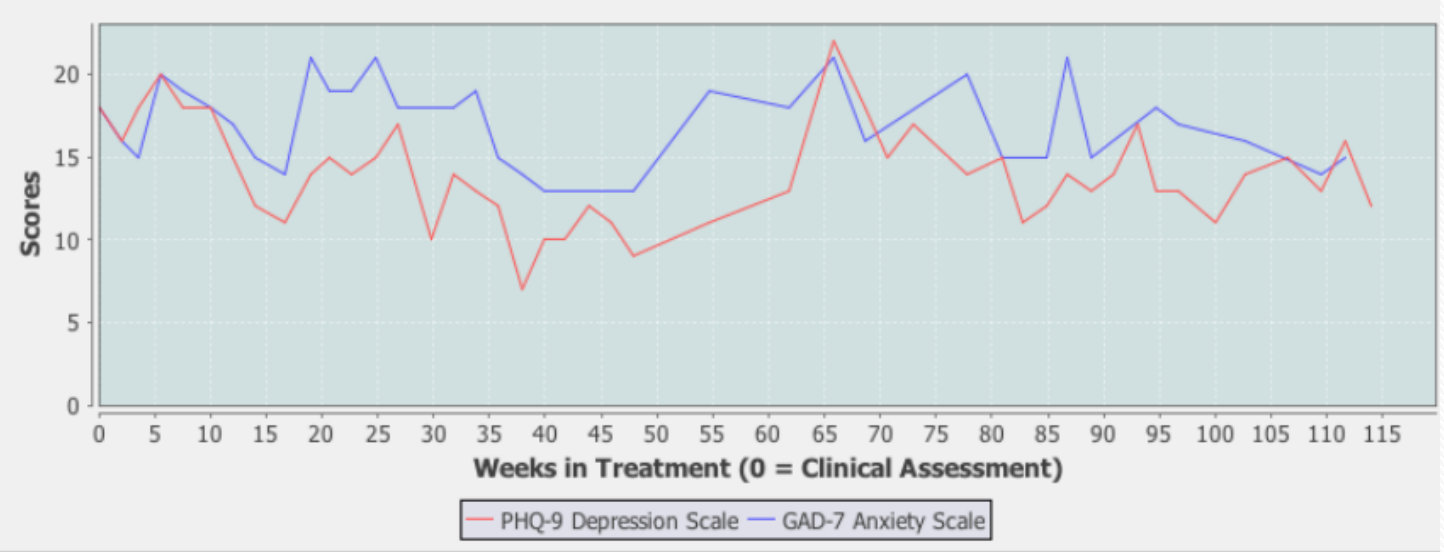
- CAGE-AID
- AUDIT

Cognitive Disorders

- Mini-Cog
- Montreal Cognitive Assessment

Principle 3:

Measurement Based Treatment To Target



Daniel and Anna (Psychiatric Consultant)

ROLE: Caseload Consultant

Caseload Reviews

- Scheduled (ideally weekly)
- Prioritize patients that are not improving

Availability to Consult Urgently

- Diagnostic dilemmas
- Education about diagnosis or medications
- Complex patients, such as pregnant or medical complicated

Common Consultation Questions

Clarification of diagnosis

- Consider re-screening patient
- Patient may need additional assessment

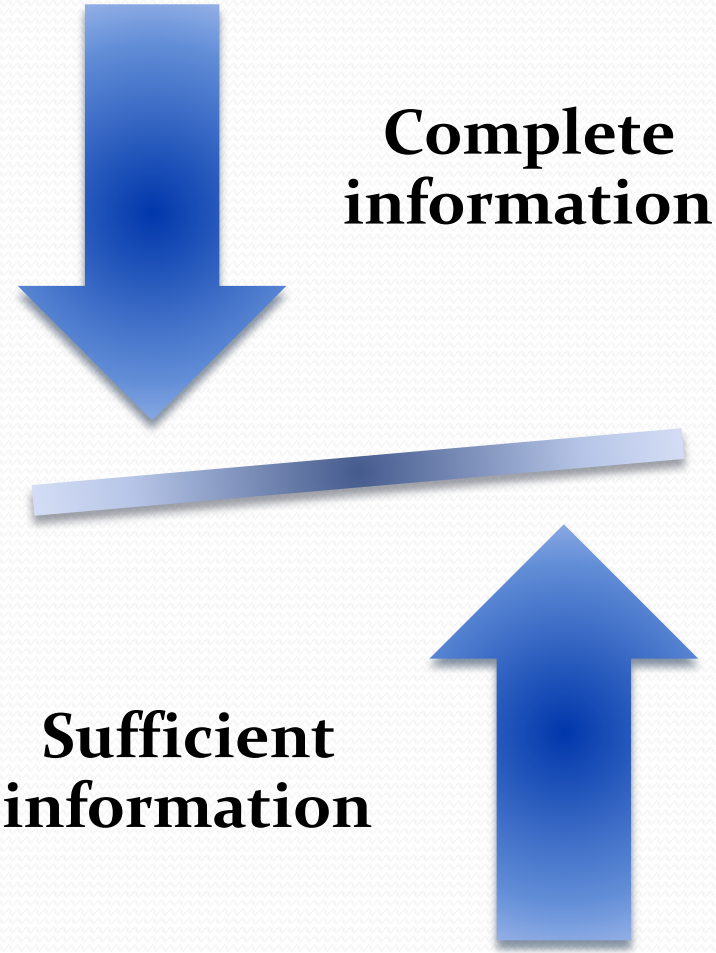
Address treatment resistant disorders

- Make sure patient has adequate dose for adequate duration
- Provide multiple additional treatment options

Recommendations for managing difficult patients

- Help differentiate crisis from distress
- Support development of treatment plans/team approach for patients with behavioral dyscontrol
- Support protocols to meet demands for opioids, benzodiazepines etc…
- Support the providers managing THEIR distress

Uncertainty: Requests for More Information



- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing

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?

Sample Consultations ~ 30 min

REASON FOR CONSULT	DIAGNOSIS	RECOMMENDATION
Med SE from lithium	BP 1	Switch to VA
SE from Vyvanse	ADHD	Try another per protocol
Li level is 1.2	BP 1	Cont unless having SE
Inc depression sx	MDNOS	TSH, if nl start Lamictal
Poss SE from Seroquel	BP 1/PD	Dec Seroquel to 100 mg
Paxil not effective	MDD	Add Wellbutrin
Reg Lamictal or XR?	BP 2	No difference
SE from Celexa	MDD	Switch to Wellbutrin
Depression sx inc	BP1	Check lithium level
Suicidal, acute distress	PD	Safety plan, therapy
High doses of meds, confused	MDD	Stop Vistaril, reduce Ativan, call collateral
Anxious, wants Xanax, nipple pain	GAD	No xanax, inc Zoloft, coping skills

Scope of Practice

What is the environment in which you are consulting and are you comfortable providing support for all these populations?

- Adults
- Children
- Pregnant patients
- Older adults
- Chronic pain
- Substance use treatment

ROLE: Direct Consultant

Seeing patients directly in collaborative care is different than traditional consultation. Approximately 5 – 7 % may need this.

Patients pre-screened from care manger population

- Already familiar with patient history and symptoms
- Typically more focused assessment, tele-video OK

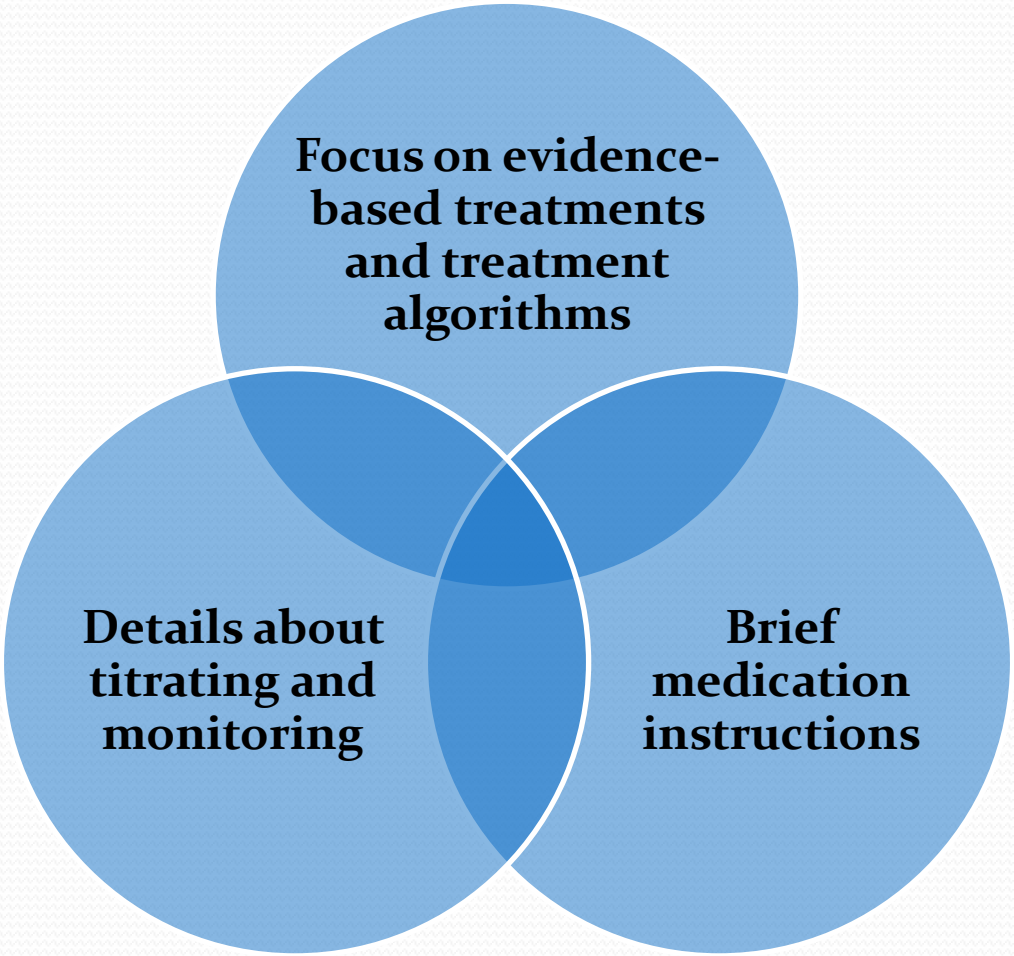
Common indications for direct assessment

- Diagnostic dilemmas
- Treatment resistance
- Education about diagnosis or medications
- Complex patients, such as pregnant or medical complicated

Principle 4:

Evidence-Based Treatment

Recommendations: Pharmacological Treatment



Evidence-based Brief Interventions

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy
- Modular Anxiety Treatment

Principle 5:

Accountable Care

CO	# OF P.	CLINICAL ASSESSMENT			FOLLOW UP				50% IMPROVED AFTER > 10 WKS	
		#	MEAN PHQ	MEAN GAD	# OF P.	MEAN #	MEAN # CLINIC	MEAN # PHONE	PHQ	GAD
LCSW	70	68 (97%)	15.1 (n=61)	12.8 (n=52)	62 (91%)	6.7	5.5 (82%)	1.2 (18%)	19 (49%) (n=39)	16 (41%) (n=39)
LCSW	86	86 (100%)	15.9 (n=86)	14.2 (n=84)	79 (92%)	12.4	6.4 (52%)	6.0 (48%)	34 (68%) (n=50)	28 (56%) (n=50)
All	156	154 (99%)	15.6 (n=147)	13.6 (n=136)	141 (92%)	9.9	6.0 (61%)	3.9 (39%)	53 (60%) (n=89)	44 (49%) (n=89)

C/C = Continued Care Pla

Psychiatrists Best Suited for this Work

- Flexible – expect the unexpected
- Adaptable - child and other populations
- Willing to tolerate interruptions
- Able to manage liability concerns
- Like teaching
- Enjoy being part of a team
- Willing to lead
- **Extending psychiatric expertise to a larger population

Blessed are the flexible for they shall not get bent out of shape.

Case Consultation Practice

1) TWO People sit back to back:
   - Psychiatric Consultant
   - PCP/BHP
2) BHP/PCP: Read vignette
3) Psychiatric Consultant: Provide consultation
   - Would you make a recommendation based on the info (consider the source - phone vs e-mail)?
   - If not, what additional information would be required (tension between uncertainty and requests for more information)?
4) Switch Roles and Repeat
5) Each person should provide two consultations