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APPLYING THE INTEGRATED CARE APPROACH:

PRACTICAL SKILLS FOR THE PSYCHIATRIC CONSULTANT

WORKSHOP: ASSESSMENT AND TREATMENT IN COLLABORATIVE CARE

FUNDING ACKNOWLEDGEMENT

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ASSESSMENT AS PART OF A COLLABORATIVE CARE TEAM

WHAT DOES A BEHAVIORAL HEALTH PATIENT LOOK LIKE IN A PRIMARY CARE SETTING?

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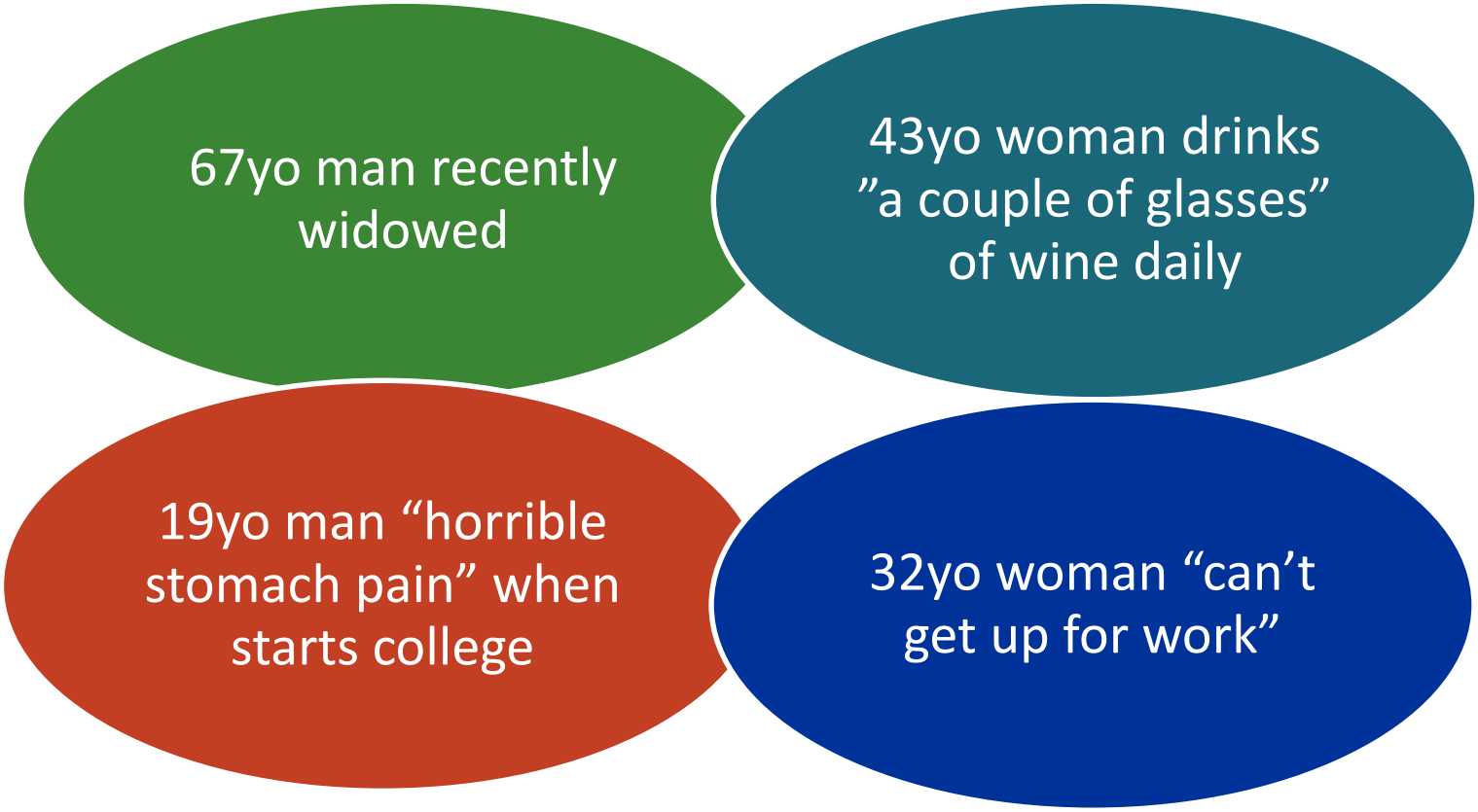

BEHAVIORAL HEALTH PATIENTS IN A PRIMARY CARE SETTING

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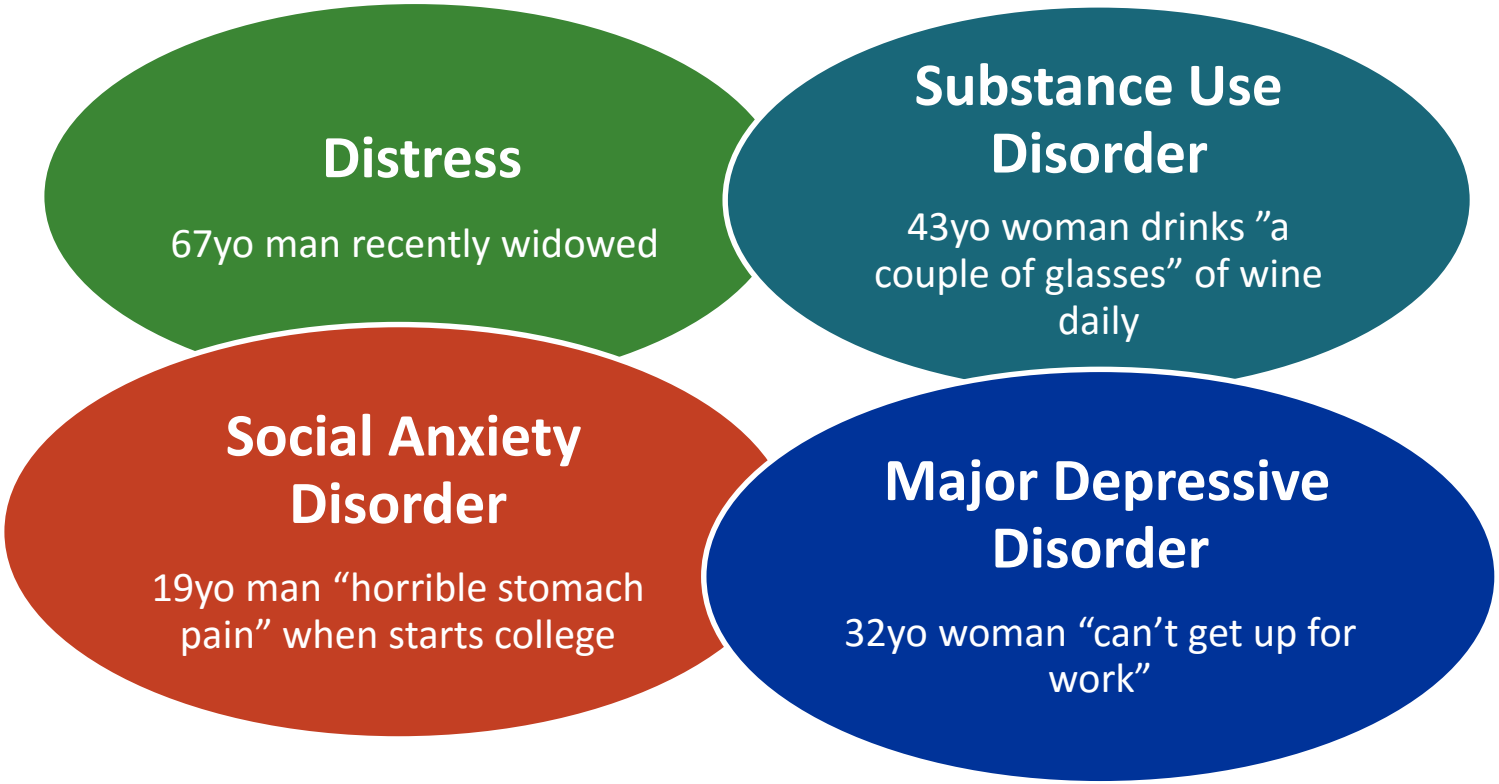

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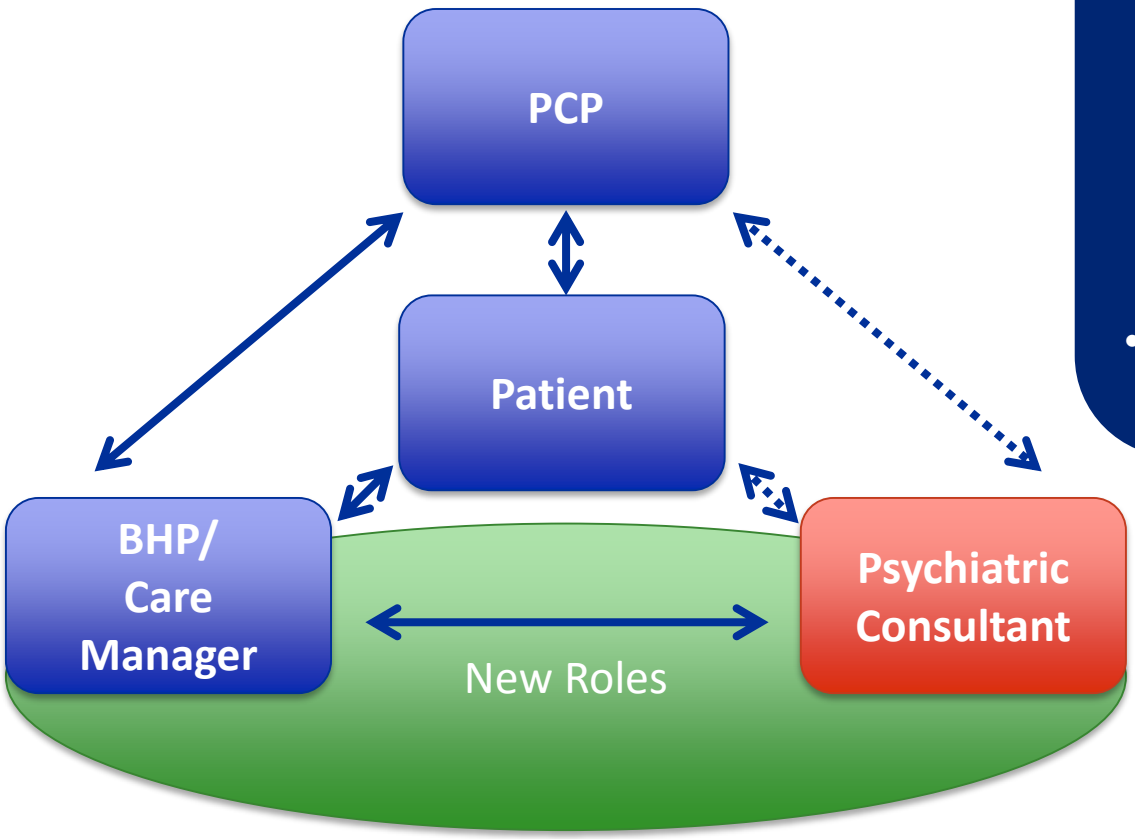
Common outpatient psychiatry presentations

- Mood disorders
- Anxiety disorders
- Substance use disorders
- Psychotic disorders
- Cognitive disorders

Common primary care presentations

- Depression
- Anxiety
- Unexplained physical symptoms
- Somatic presentations & somatoform disorders
- Acute and chronic distress
- Adjustment disorders
- Pain

PSYCHIATRIC CONSULTANT ROLE



CASELOAD CONSULTANT

- Review cases with the care manager using the registry
  - ✓ Scheduled (ideally weekly)
  - ✓ Prioritize patients that are not improving
- Consult urgently (as needed)

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COMMON CONSULTATION QUESTIONS

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- **Clarifying diagnosis**
- **Addressing treatment resistant disorders**
- **Making recommendations for managing difficult patients**

A DIFFERENT KIND OF ASSESSMENT: CARE SHAPED OVER TIME

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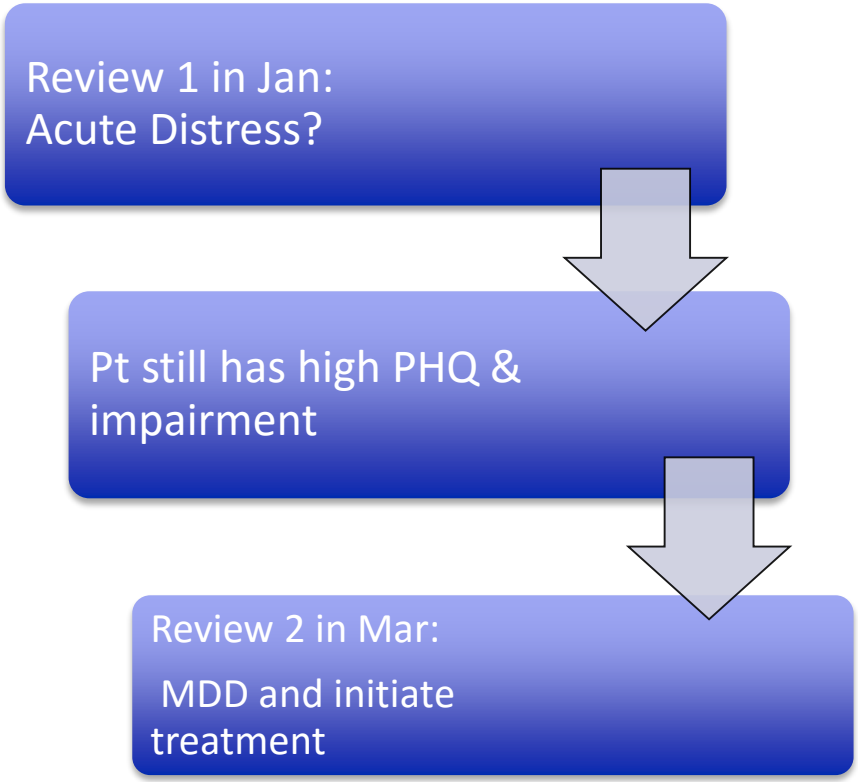
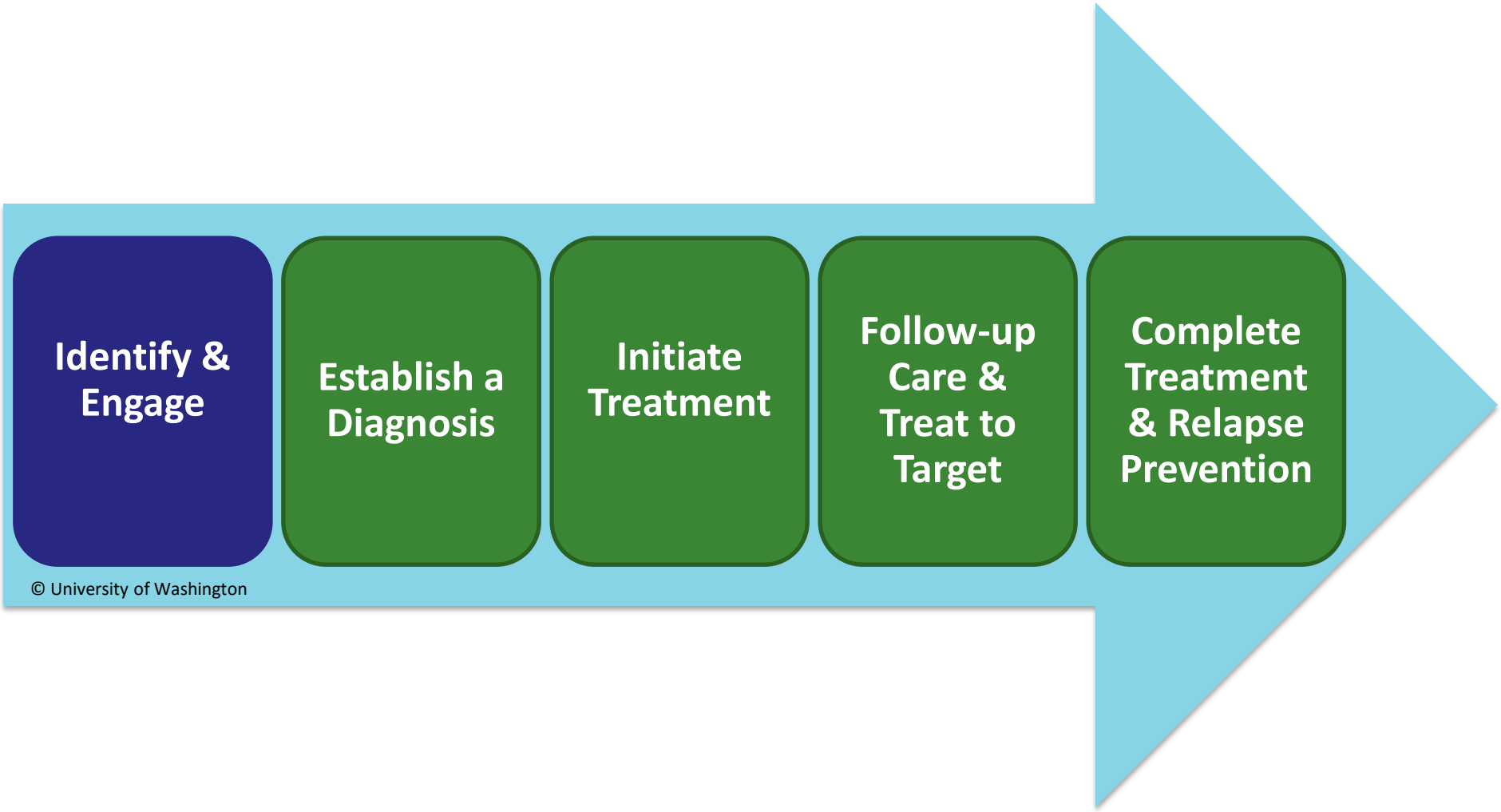
Traditional Consult

One Session = One Assessment

Collaborative Care Case Review



IDENTIFY & ENGAGE



A DIFFERENT KIND OF ASSESSMENT: USING BEHAVIORAL HEALTH MEASURES

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Mood Disorders

- PHQ-2, PHQ-9: Depression
- MDQ: Bipolar disorder
- CIDI 3.0: Bipolar disorder

Anxiety and Trauma Disorders

- GAD- 7: Anxiety
- PCL-C: PTSD

Substance Use Disorders

- CAGE-AID
- AUDIT

Cognitive Disorders

- Mini-Cog
- Montreal Cognitive Assessment

BEHAVIORAL HEALTH MEASURES AS "VITAL SIGNS"

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Behavioral health measures are like monitoring blood pressure!

- Identifies that there is a problem
- Needs further assessment to understand the cause of the "abnormality"
- Helps with ongoing monitoring to measure response to treatment

PHQ-2

Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

- Ultra brief screening
- Commonly used in primary care
- Scoring:
  - 0-2: Negative
  - 3 or Higher: Positive and patient needs further assessment

PHQ-9

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Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

	Not difficult at all	Somewhat difficult	Very Difficult	Extremely difficult

UNDERSTANDING THE PHQ-9 SCORE

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Score	Severity
0 – 4	No Depression
5 – 9	Mild Depression
10 – 14	Moderate Depression
≥ 15	Severe Depression

Are there safety concerns?
If Question 9 is a score > 0, needs to be assessed for safety

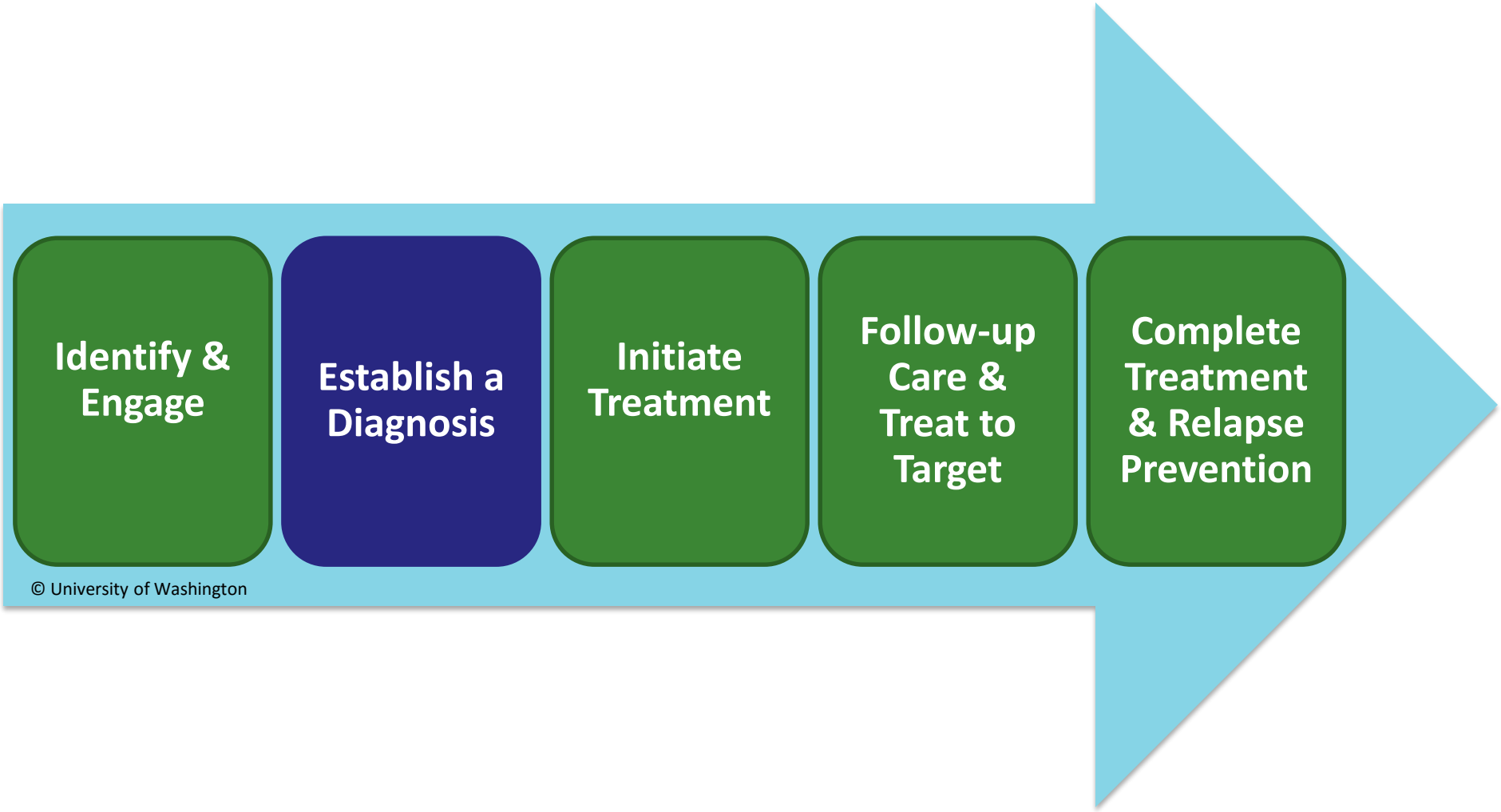
Is it depression?
MDD: needs to have either Question 1 or Question 2 with a score of >2

WHO SHOULD GET SCREENED?

Population	Recommendation	Grade
General adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	**The USPSTF recommends the service.** There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

Adapted from: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1?ds=1&s=Depression

ESTABLISH A DIAGNOSIS



INDIRECT ASSESSMENT AND DIAGNOSIS

Functioning as a "back seat driver"

- Develop an understanding of the relative strengths and limitations of the providers on your team
- Rely on other providers (PCP and BHP/care manager) to gather history

How do you "steer"?

- Structure your information gathering
- Include assessment of functional impairment
- Pay attention to mental status exam
- Help team improve differential diagnosis skills

EXAMPLE: STRUCTURED ASSESSMENT

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BHP/care manager is asked to briefly report on:

- 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

BASIC DIFFERENTIAL DIAGNOSIS

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Mood

- Depression
- Mania/Hypomania

Anxiety and Trauma Disorders

- Generalized anxiety
- Panic attacks
- PTSD
- OCD

Psychosis

- Primary
- Secondary

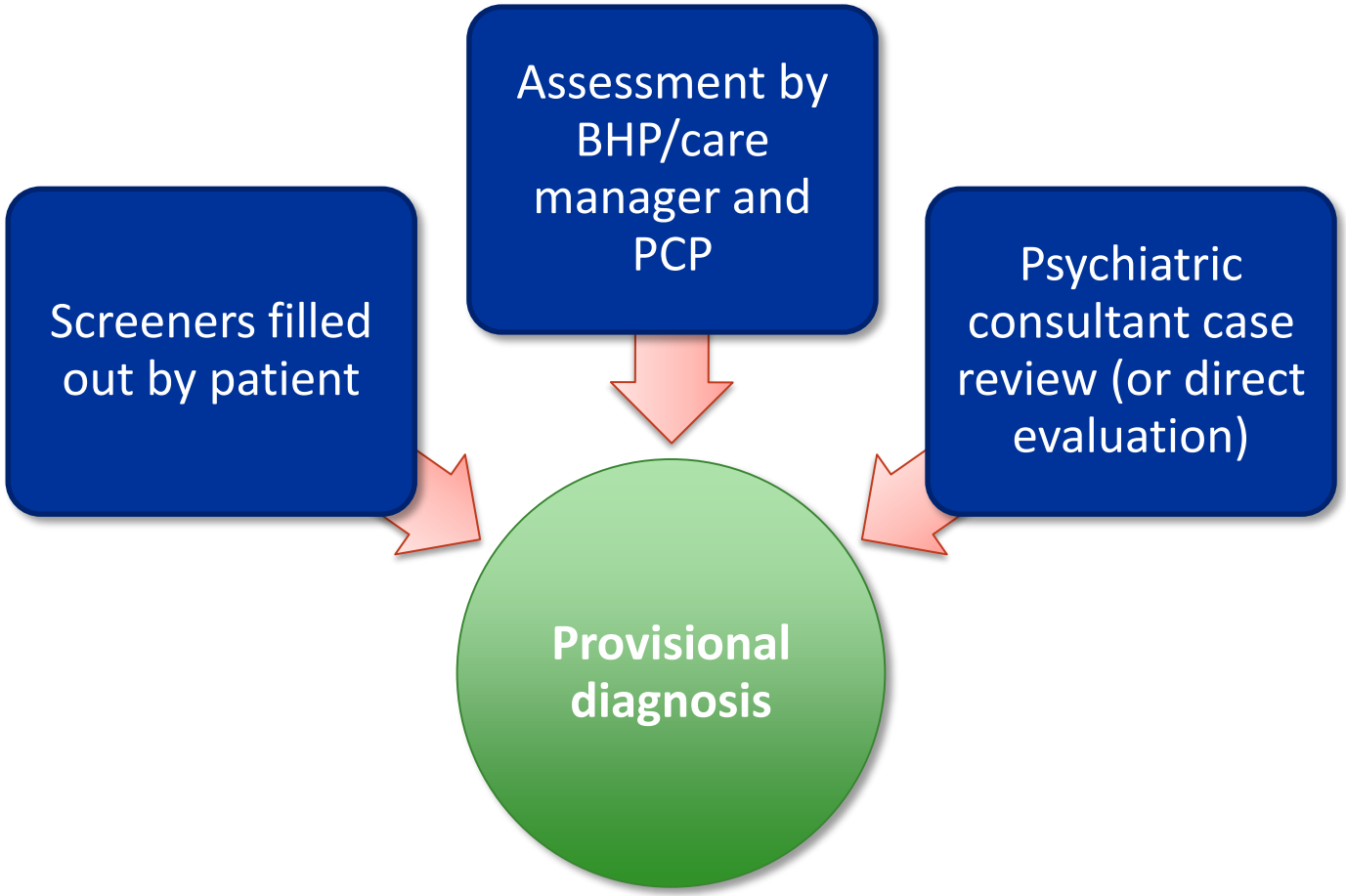
Substance Use

- Alcohol
- Illicit
- Prescription

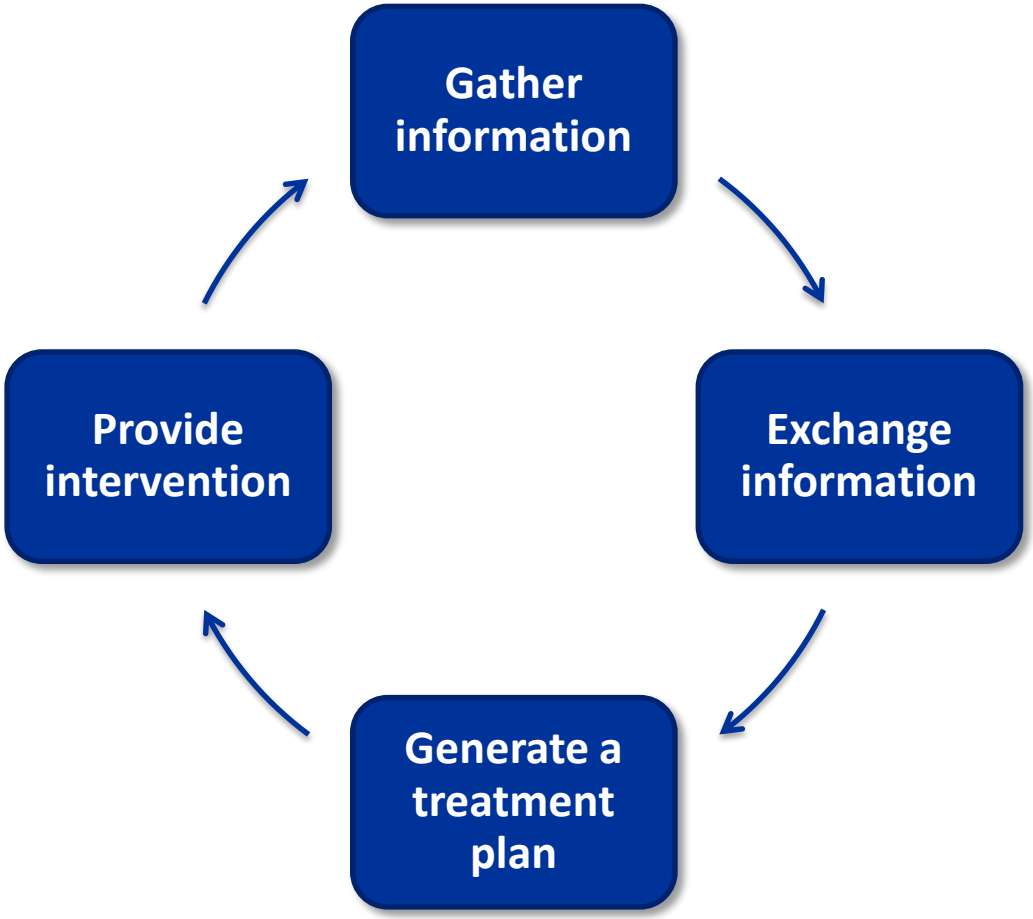
Organic

- Cognitive function
- Relevant medical history

PROVISIONAL DIAGNOSIS

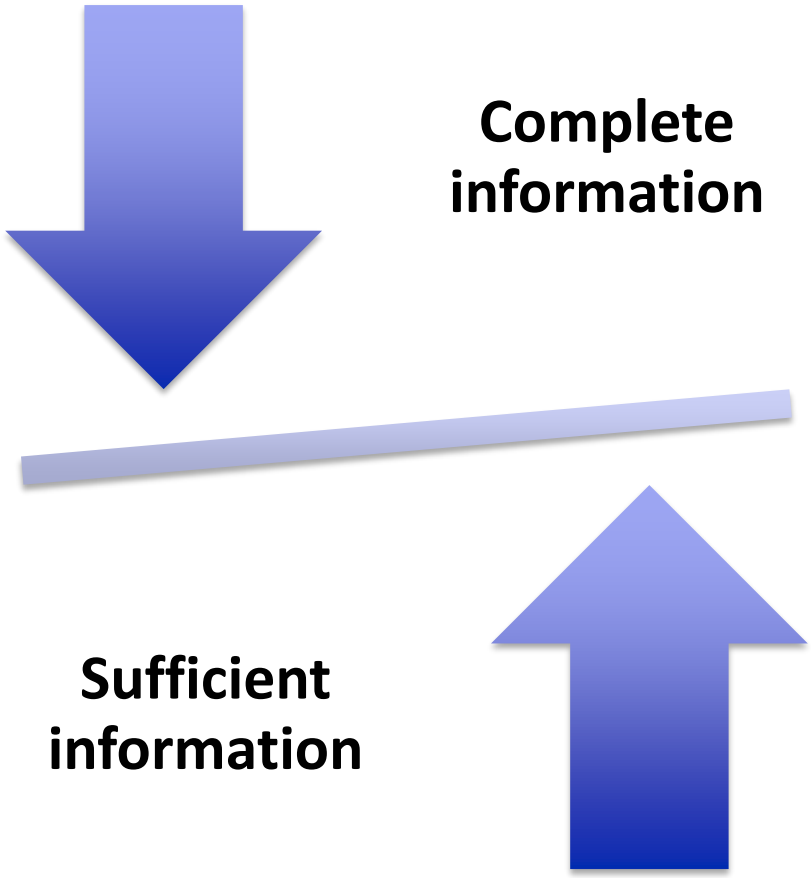


ASSESSMENT AND DIAGNOSIS IN THE PRIMARY CARE CLINIC



- Diagnosis can require multiple iterations of assessment and intervention
- Advantage of population-based care is longitudinal observation and objective data
- Start with diagnosis that is your 'best understanding' and can adjust over time

TOLERATING UNCERTAINTY



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

PSYCHIATRIC CONSULTANT ROLE: DIRECT CONSULTANT

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- **Different than seeing patients in traditional consultation**
- **Approximately 5 – 7 % of patients may need direct consultation**

Patients pre-screened from care manager 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 medically complicated

PRACTICE CASES

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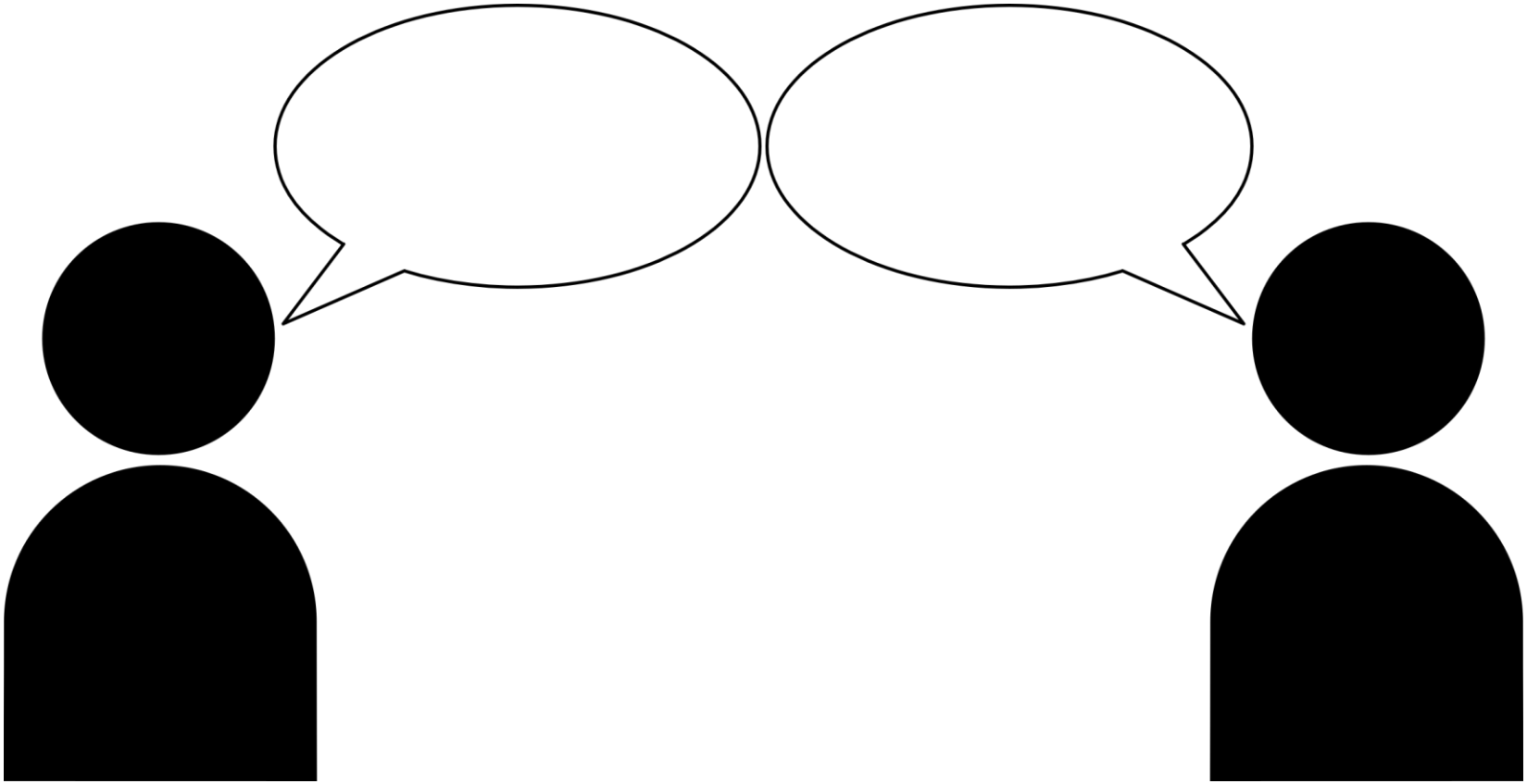

CIDI-3

The first part of the CIDI-3 consists of asking two stem questions. If either Question 1 or Question 2 is positive, continue with the criterion B Screening Question. If both are negative, than the measure is negative and the patient does not likely meet the criteria for bipolar disorder.:

Euphoria Stem Question:

1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?

   If this question is endorsed, the next question (Irritability Stem Question) is skipped and the respondent goes directly to the Criterion B screening question.

Irritability Stem Question:

2. Have you ever had a period lasting several days or longer when most of the time you were so irritable and grouchy you either started arguments, shouted at people or hit people?

Criterion B Screening Question

3. People who have episodes like this often have changes in their thinking and behavioral at the same time, like being more talkative, needing very little sleep, being very restless, going on spending sprees, and behaving in many ways they would normally think inappropriate ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?

CIDI-3

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CIDI-3 for Bipolar Disorder: Criterion B Symptom Questions

Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?

1. Were so irritable that you either started arguments, shouted at people or hit people?
2. Did you become so restless or fidgety that you paced up and down or couldn't stand still?
3. Did you do anything else that wasn't usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?
4. Did you try to do things that were impossible to do, like taking on large amounts of work?
5. Did you constantly keep changing your plans or activities?
6. Did you find it hard to keep your mind on what you were doing?
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?
8. Did you sleep far less than usual and still not get tired or sleepy?
9. Did you spend so much more money than usual that it caused you to have financial trouble?

EXERCISE 2: PRACTICE COLLABORATIVE CARE CASE REVIEWS

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- Find a partner
- Take turns playing the psychiatric consultant for one case
- Use NicelyDONE

Workbook pages 6-9

QUESTIONS?

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TREATMENT AS PART OF A COLLABORATIVE CARE TEAM

A DIFFERENT KIND OF TREATMENT: CARE SHAPED OVER TIME

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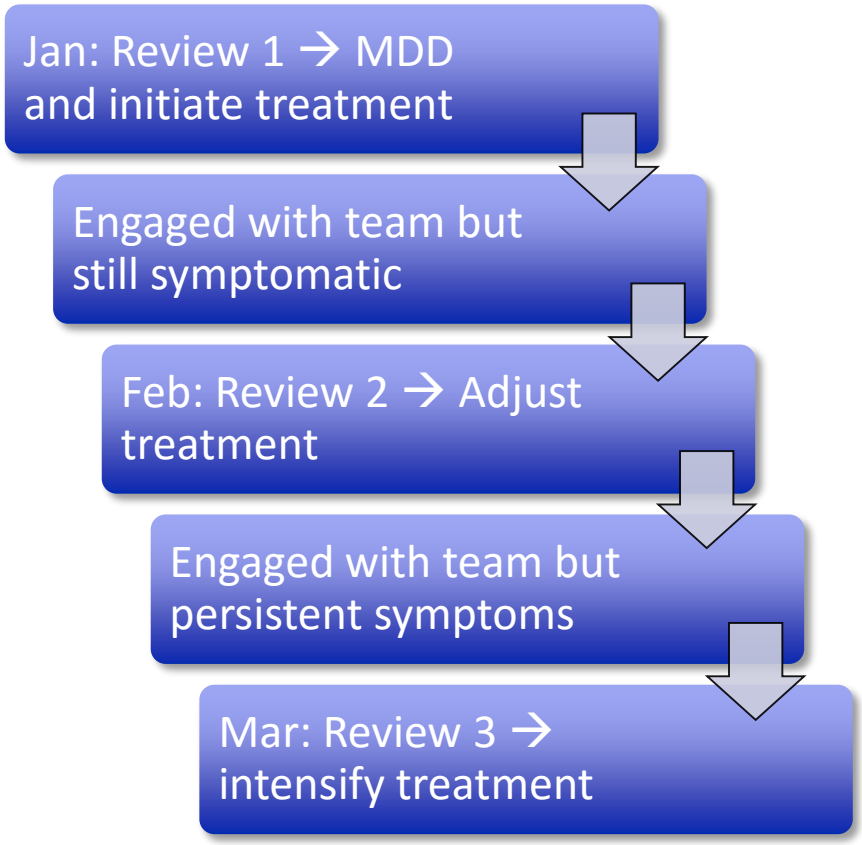
Traditional Consult

One Session = One Time Recommendation

Collaborative Care



INITIATE TREATMENT

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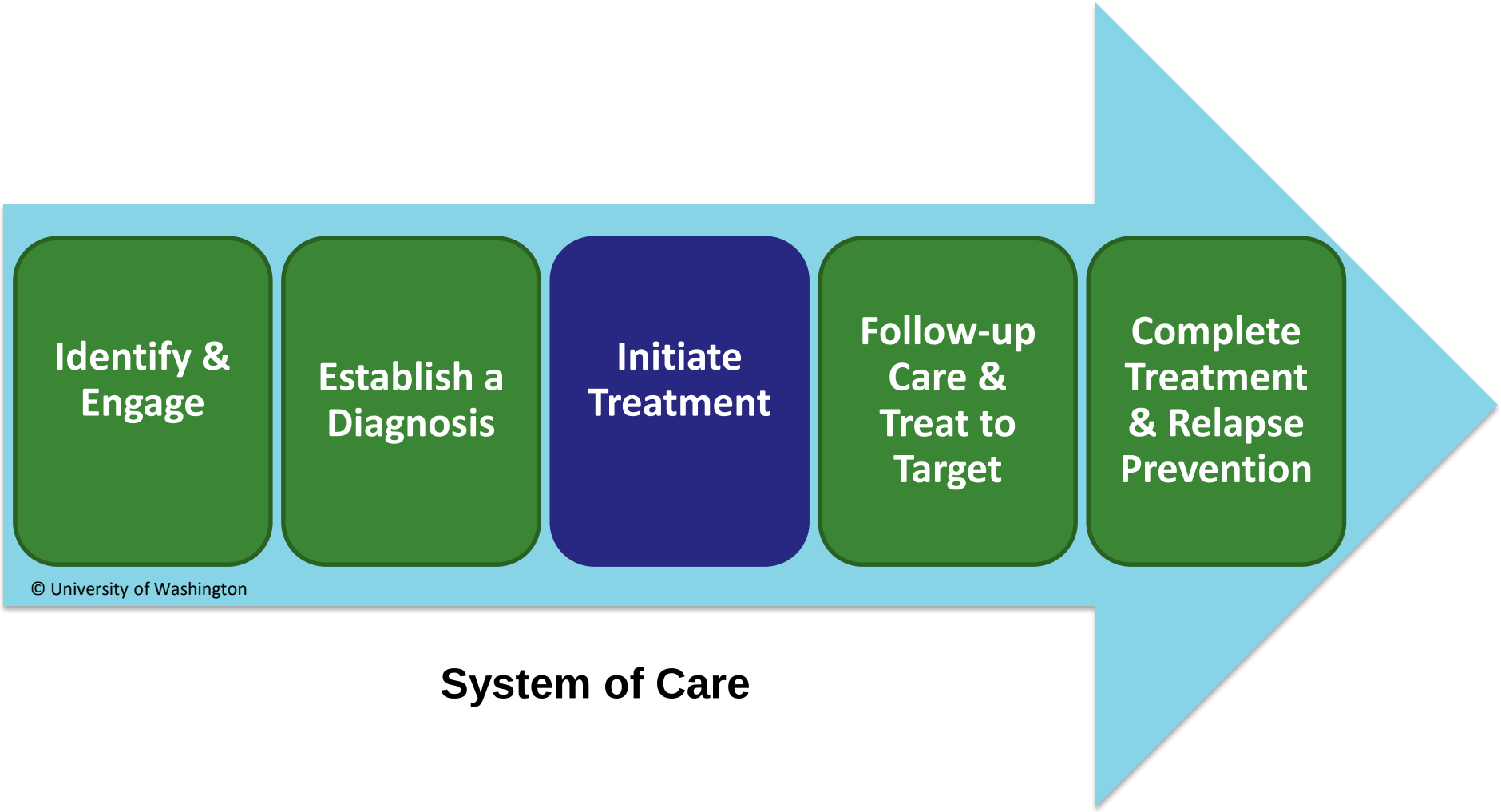

System of Care

PRINCIPLES OF COLLABORATIVE CARE

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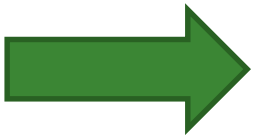
Population-Based Care

Measurement-Based Treatment to Target

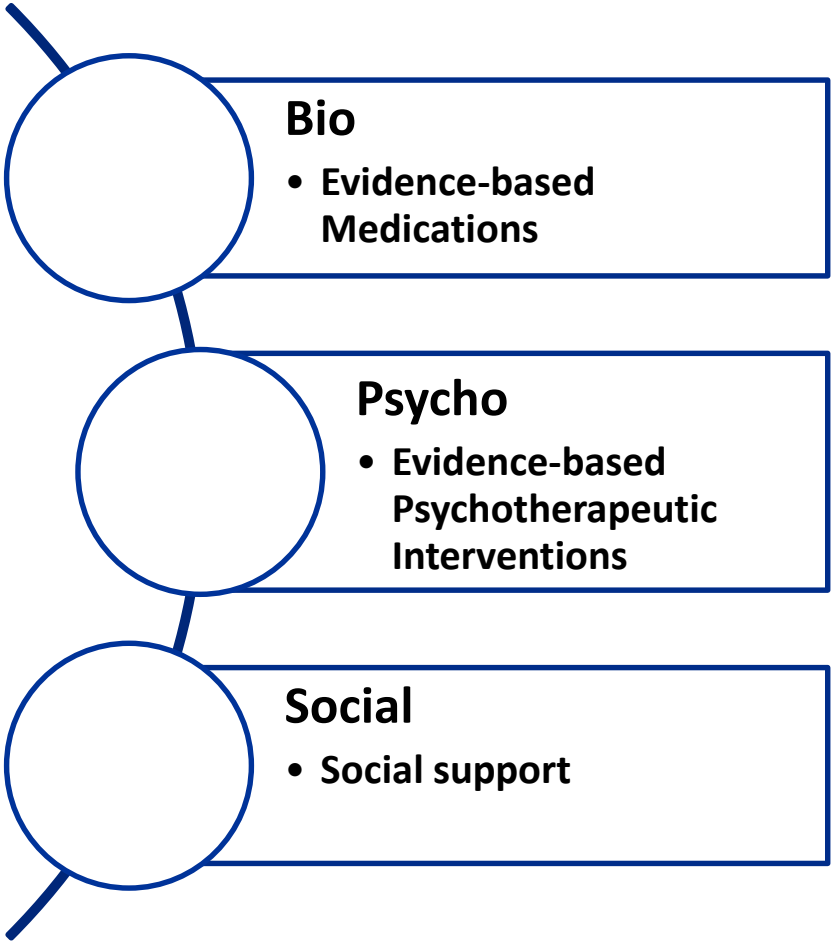
Patient-Centered Collaboration



Evidence-Based Care

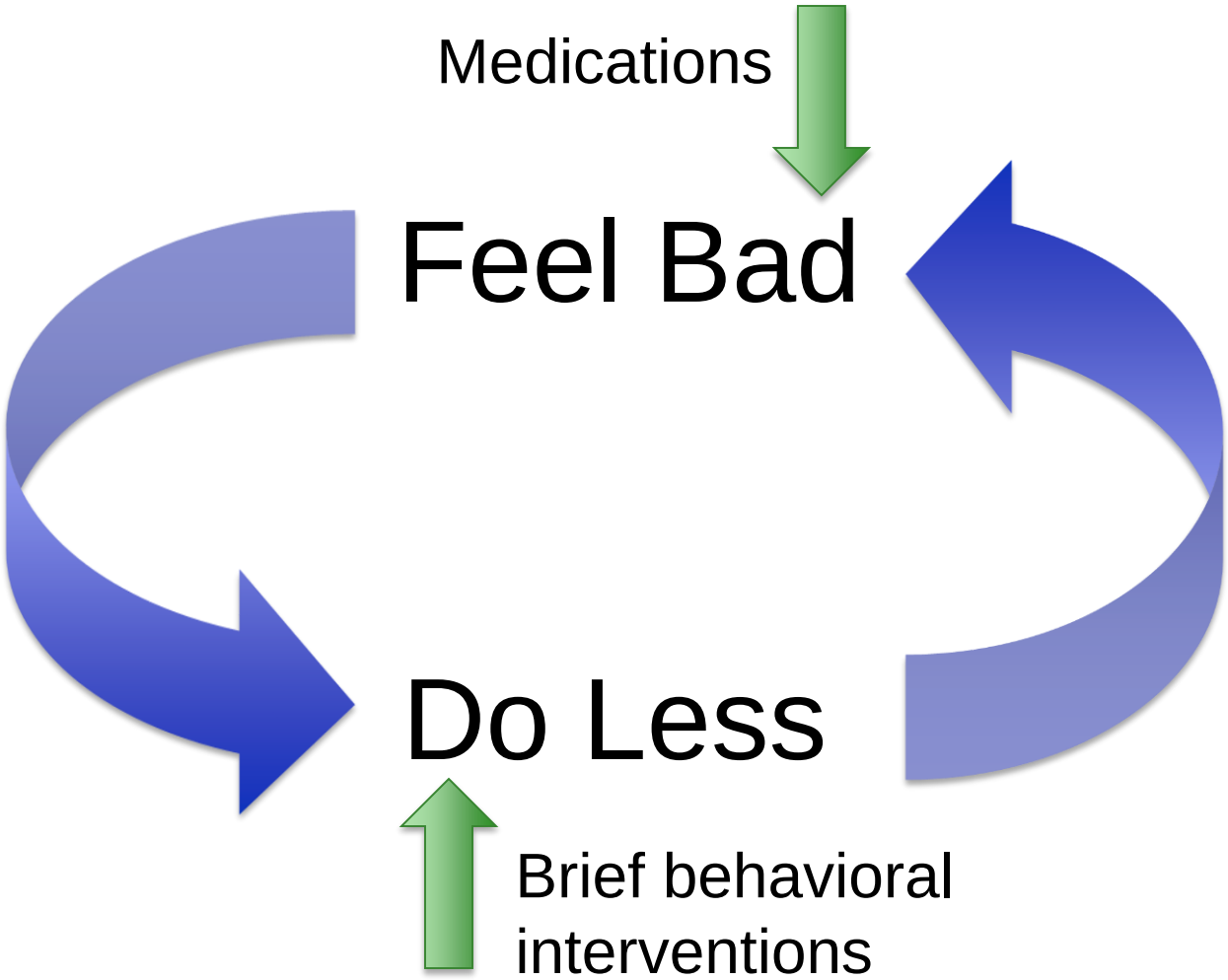
Accountable Care

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

MODEL OF DEPRESSION



EXAMPLES OF EVIDENCE-BASED BEHAVIORAL APPROACHES

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Disorder	Evidence-Based Behavioral Approaches
Major Depression	Problem-Solving Treatment Behavioral Activation Cognitive Behavioral Therapy Interpersonal Therapy
Anxiety Disorders	Modular Anxiety Treatment (CALM) Cognitive Behavioral Therapy
PTSD	Cognitive Processing Therapy Prolonged Exposure
Substance Use Disorders	Harm Reduction Motivational Interviewing Brief Interventions for Alcohol
Chronic Pain	Cognitive Behavioral Therapy • Negative thoughts about chronic pain • Pain interference in life • Acceptance of chronic pain • Pain self-management strategies

RECOMMENDATIONS: MEDICATION TREATMENT

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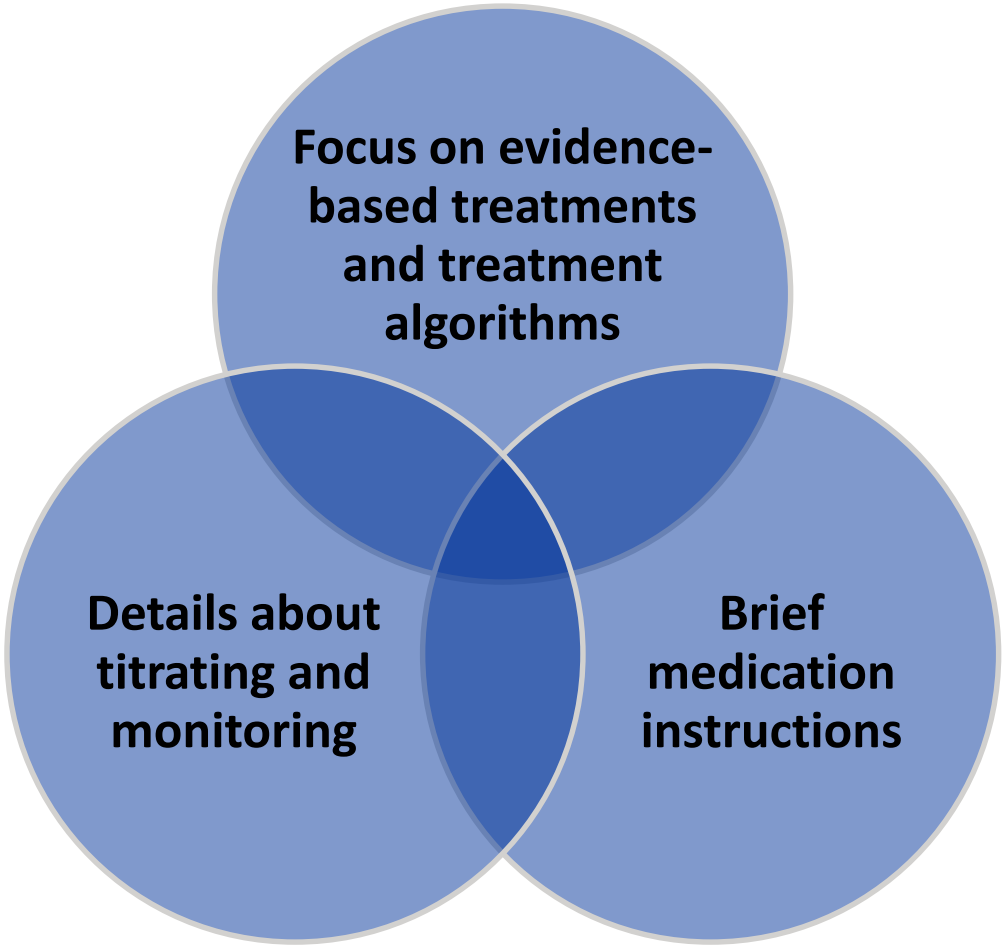

EXAMPLE: PRESCRIBING CHEAT SHEET

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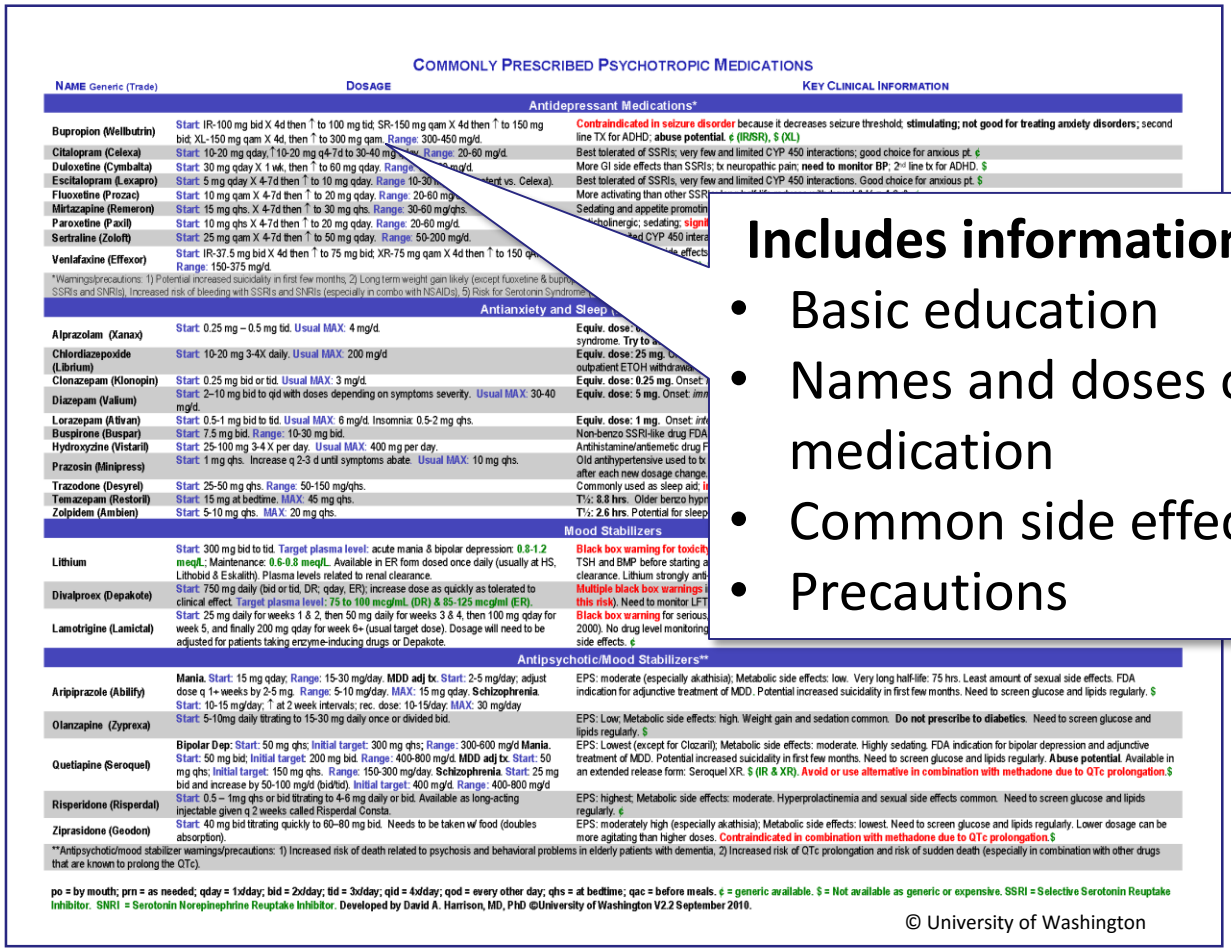

COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS

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: 300-450 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: 20-60 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: [illegible] 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 [illegible] vs. Celexa).	Best tolerated of SSRIs, very few and limited CYP 450 interactions. Good choice for anxious pt. $
Fluoxetine (Prozac)	Start: 10 mg qam X 4-7d then ↑ to 20 mg qday. Range: 20-60 mg	More activating than other SSRI
Mirtazapine (Remeron)	Start: 15 mg qhs. X 4-7d then ↑ to 30 mg qhs. Range: 30-60 mg/qhs.	Sedating and appetite promotin
Paroxetine (Paxil)	Start: 10 mg qhs X 4-7d then ↑ to 20 mg qday. Range: 20-60 mg/d.	cholinergic; sedating; signi
Sertraline (Zoloft)	Start: 25 mg qam X 4-7d then ↑ to 50 mg qday. Range: 50-200 mg/d.	ed CYP 450 intera
Venlafaxine (Effexor)	Start: IR-37.5 mg bid X 4d then ↑ to 75 mg bid; XR-75 mg qam X 4d then ↑ to 150 q Range: 150-375 mg/d.	de effects
*Warnings/precautions: 1) Potential increased suicidality in first few months, 2) Long term weight gain likely (except fluoxetine & bupro SSRIs and SNRIs), Increased risk of bleeding with SSRIs and SNRIs (especially in combo with NSAIDs), 5) Risk for Serotonin Syndrome		
Antianxiety and Sleep		
Alprazolam (Xanax)	Start: 0.25 mg – 0.5 mg tid. Usual MAX: 4 mg/d.	Equiv. dose: syndrome. Try to
Chlordiazepoxide (Librium)	Start: 10-20 mg 3-4X daily. Usual MAX: 200 mg/d	Equiv. dose: 25 mg. outpatient ETOH withdraw
Clonazepam (Klonopin)	Start: 0.25 mg bid or tid. Usual MAX: 3 mg/d.	Equiv. dose: 0.25 mg. Onset:
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. Onset:
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. Onset:
Buspirone (Buspar)	Start: 7.5 mg bid. Range: 10-30 mg bid.	Non-benzo SSRI-like drug FDA
Hydroxyzine (Vistaril)	Start: 25-100 mg 3-4 X per day. Usual MAX: 400 mg per day.	Antihistamine/antiemetic drug F
Prazosin (Minipress)	Start: 1 mg qhs. Increase q 2-3 d until symptoms abate. Usual MAX: 10 mg qhs.	Old antihypertensive used to tx after each new dosage change.
Trazodone (Desyrel)	Start: 25-50 mg qhs. Range: 50-150 mg/qhs.	Commonly used as sleep aid;
Temazepam (Restoril)	Start: 15 mg at bedtime. MAX: 45 mg qhs.	T½: 8.8 hrs. Older benzo hypr
Zolpidem (Ambien)	Start: 5-10 mg qhs. MAX: 20 mg qhs.	T½: 2.6 hrs. Potential for sleep
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 for toxicit TSH and BMP before starting a clearance. Lithium strongly anti-
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 warnings this risk). Need to monitor LFT
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 2000). No drug level monitoring 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

https://aims.uw.edu/sites/default/files/PsychotropicMedications_0.pdf

Sample Case Review Note

SUMMARY: Pt is a 28yo male presenting with depression and anxiety. 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

MAKING EFFECTIVE RECOMMENDATIONS

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

EXAMPLE: 'DISCLAIMER' ON CONSULTATION NOTE

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"The above treatment considerations and suggestions are based on consultations with the patient's care manager and a review of information available in the Mental Health Integrated Tracking System (MHITS). I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient."

- Dr. X, Psychiatric Consultant
- Phone #
- Pager #
- E-mail

FOLLOW-UP CARE & TREAT TO TARGET

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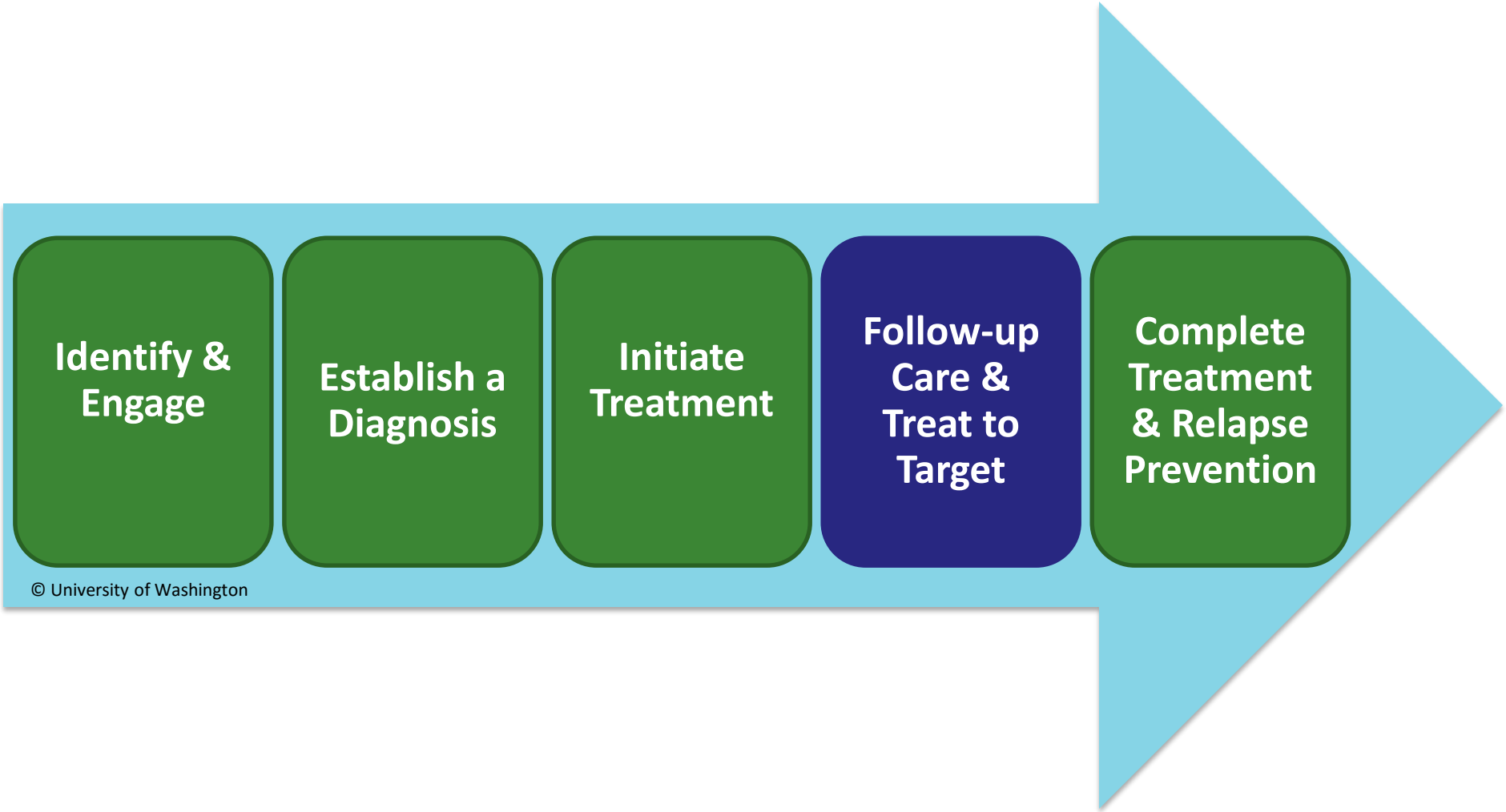

PRINCIPLE:
POPULATION-BASED TREATMENT

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Caseload Overview

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

PRINCIPLE: **MEASUREMENT-BASED TREATMENT TO TARGET**

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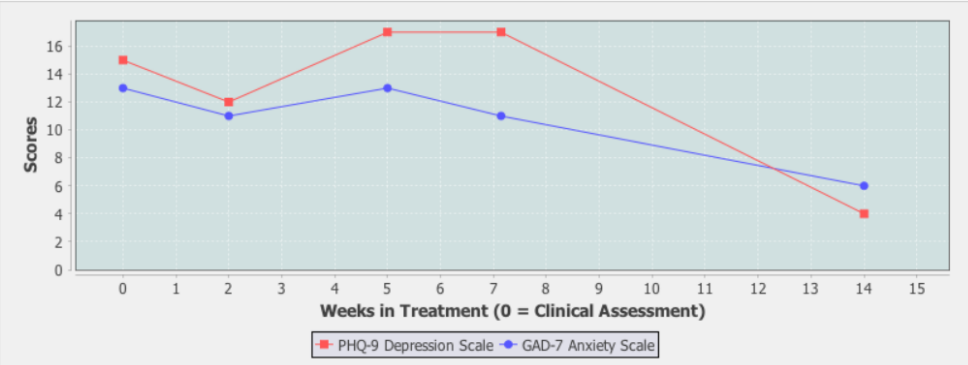
Patient | Caseload | Program | Tools | Search Name or MHITS ID | Hello, Anna (aratzliff) | Help | Logou

Date of Contact	Contact Type	Weeks in Tx	Visit Type	PHQ-9	GAD-7	Bipolar Screen	PTSD Screen	Current Medications
1/19/2016	Clinical Assessment	0	Clinic	15	13	√	√	
1/29/2016	Psychiatric Consultation Note	1	Phone w/ CC					
2/2/2016	Follow Up Contact	2	Clinic	12	11			
2/5/2016	Follow Up Contact	2	Phone					
2/10/2016	Psychiatric Consultation Note	3	Phone w/ CC					
2/10/2016	Psychiatric Consultation Note	3	Phone w/ CC					
2/23/2016	Follow Up Contact	5	Clinic	17	13			Fluoxetine HCl (Prozac) 10mg
3/9/2016	Follow Up Contact	7	Clinic	17	11			Fluoxetine HCl (Prozac) 20mg
3/18/2016	Follow Up Contact	8	Phone					†Fluoxetine HCl (Prozac) 20mg
4/26/2016	Follow Up Contact	14	Clinic	4	6			†Fluoxetine HCl (Prozac) 20mg

Collateral Contacts

Date of Contact	Name	Role	Agency	Contact Information
No Records Found				

Patient Progress



STAR-D SUMMARY

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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 treatment

~70% in remission

Rush, 2007

TYPICAL COURSE OF CARE MANAGEMENT: CONTACT FREQUENCY

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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
  - Both phone and in-person contacts are appropriate

Monitoring

- 1 contact per month
  - After 50% decrease in PHQ/GAD (or similar) achieved
  - Monitor for ~3 months to ensure patient's mood symptoms are stable

COMPARISON OF CONTACTS: USUAL CARE

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Usual Care

3.5 PCP Contacts per year*

= PCP contact

20% - 40% treatment response/improvement

*Based on HRSA report of average PCP visit rates for FQHCs

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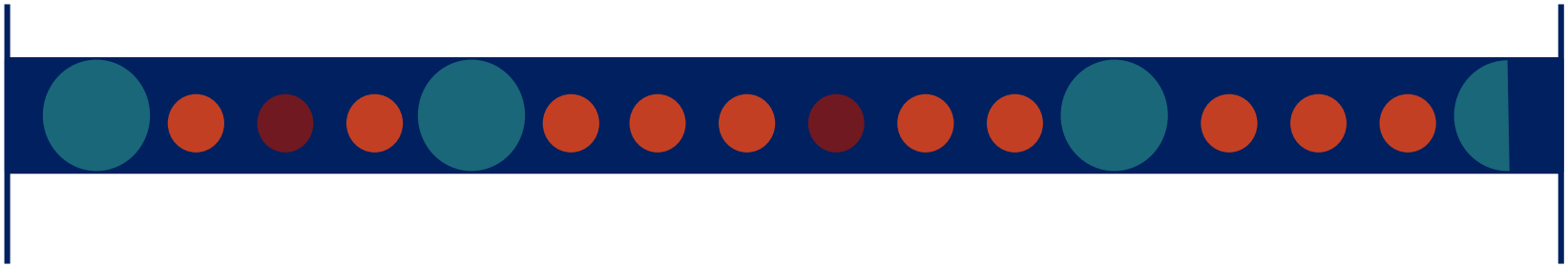
Collaborative Care

= 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)



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12 months

50% - 70% treatment response/improvement

TREATMENT IN THE PRIMARY CARE CLINIC

Functioning as a "back seat driver"

- Develop an understanding of the relative strengths and limitations of the providers on your team
- Rely on other providers (PCP and BHP/care manager) to gather history

How do you "steer"?

- Structure your information gathering
- Include assessment of functional impairment
- Pay attention to mental status exam

WEEKLY CASELOAD CONSULTATION

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BHP/Care Manager

Photo credit: Courtesy of the John A. Hartford Foundation

Psychiatric Consultant

Photo: © University of Washington

MODEL CONSULTATION HOUR

- Brief check-in
  - Changes in the clinic
  - Systems questions
- BOTH looking at registry during consultation hour
- Identify patients and conduct reviews
  - Requested by BHP/CM
  - Not improved w/o note
  - Severity of presentation
  - Disengaged from care
  - Ready for relapse prevention or referral
- Wrap up
  - Confirm next consultation hour
  - Send any educational resources discussed

IF PATIENTS DO NOT IMPROVE, CONSIDER:

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- Wrong diagnosis?
- Problems with treatment adherence?
- Insufficient dose/duration of treatment?
- Side effects?
- Initial treatment not effective?
- Other complicating factors?
  - psychosocial stressors/barriers
  - medical problems/medications
  - 'psychological' barriers
  - substance abuse
  - other psychiatric problems

RECOMMENDATIONS: OTHER INTERVENTIONS

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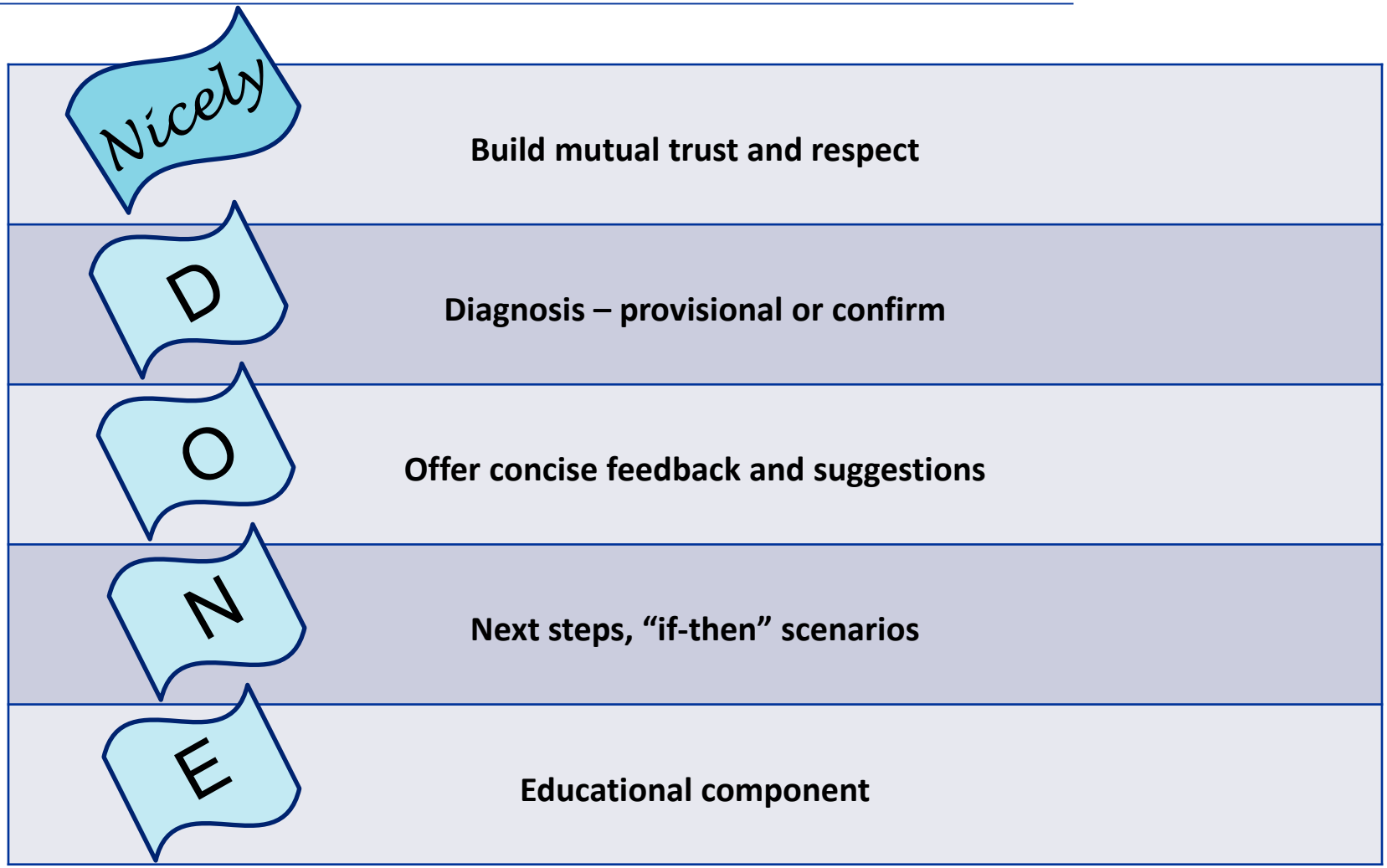
Beyond medications

- Behavioral, brief psychotherapy
- Referrals and community resources

Support managing difficult patients

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

NICELY DONE



Used with permission from Lori Raney, MD

COMPLETE TREATMENT & RELAPSE PREVENTION

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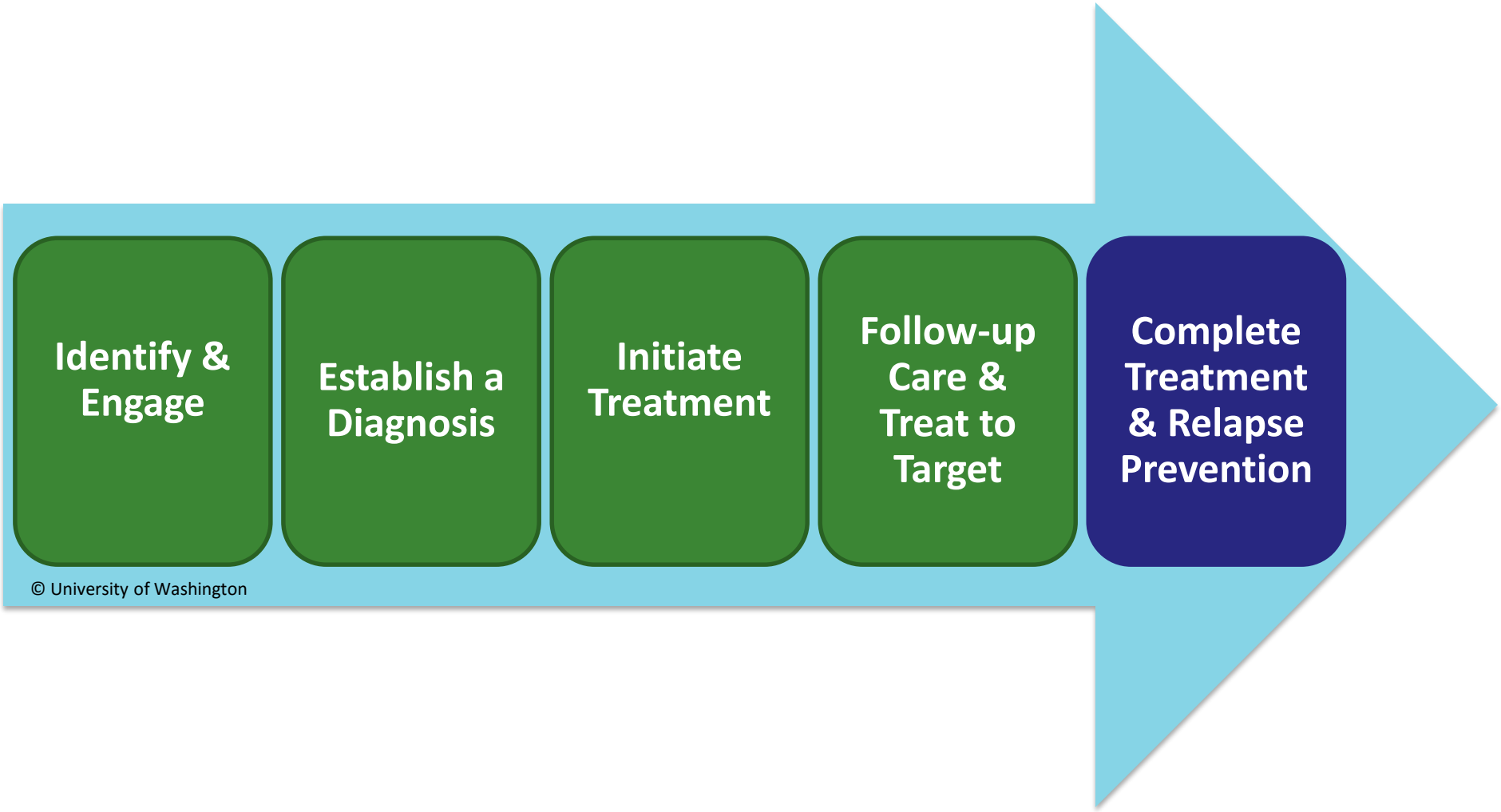
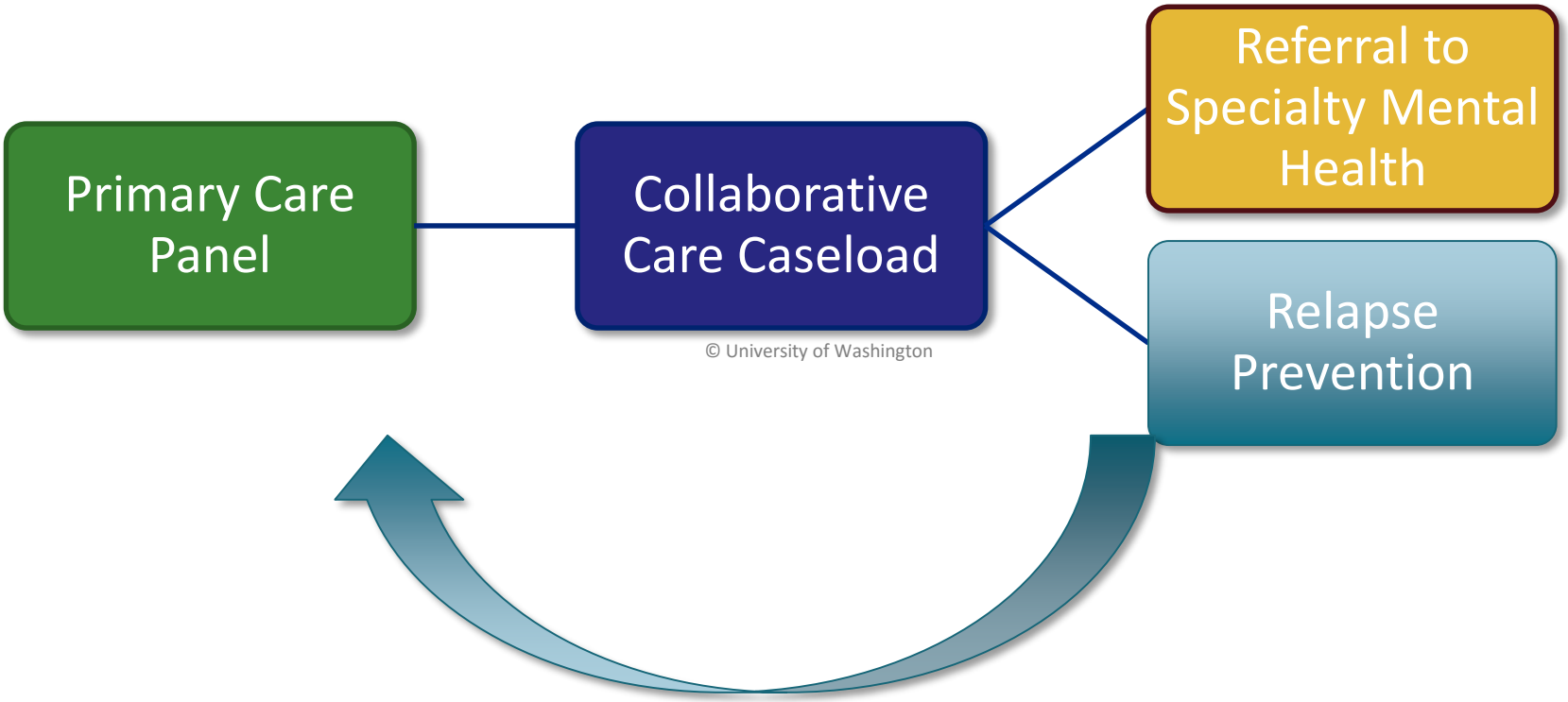


TYPICAL COURSE OF CARE MANAGEMENT: DURATION



PRACTICE CASES - REGISTRY

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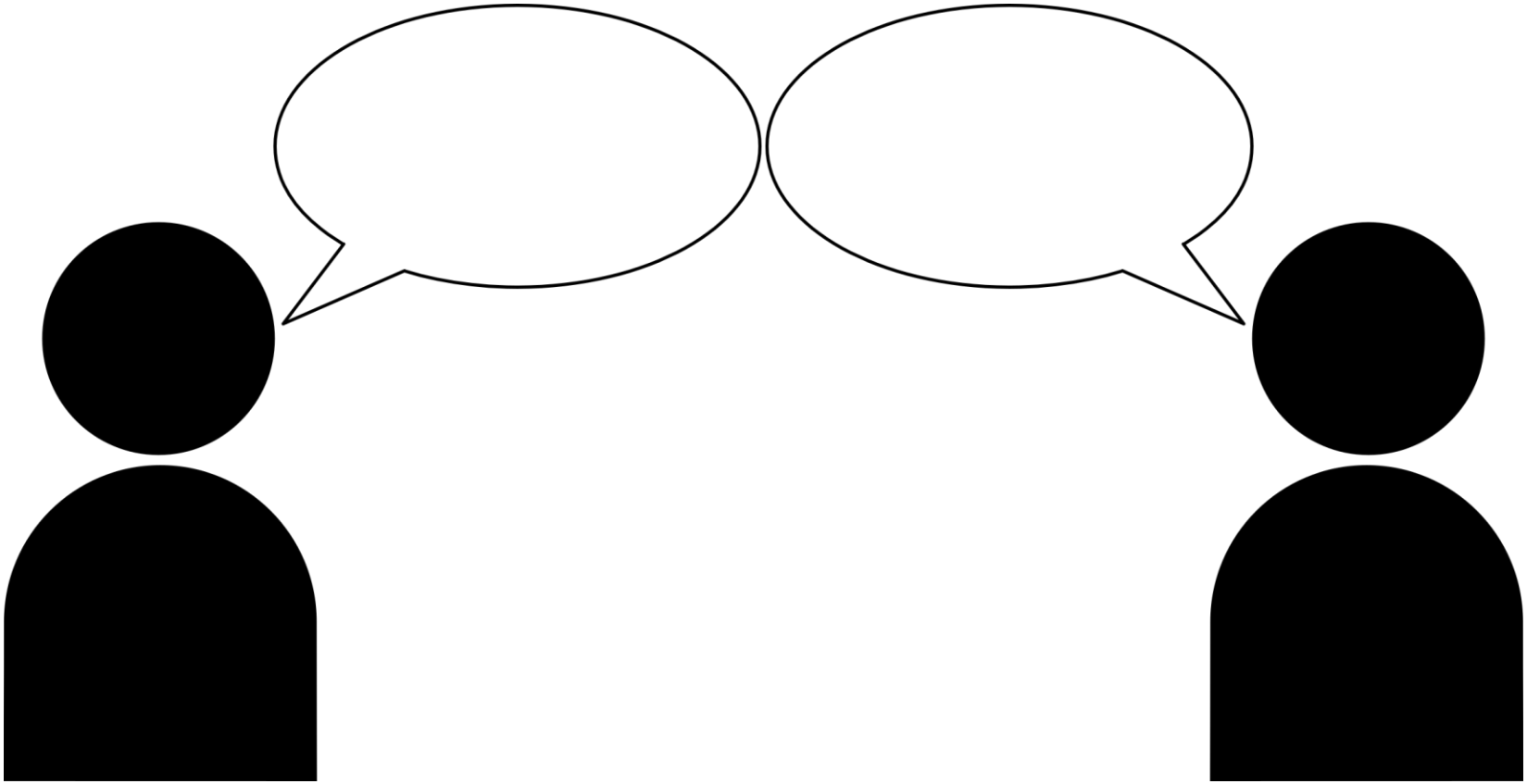

EXERCISE 3: USING A REGISTRY

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Processes of care:

- Clinical Assessment →Goal: Completed
- Follow-up Contacts → Goal: Contact 2X per month
  % of active patients with psychiatric consultation note → Goal: patients without improvement every 2 months

Clinical outcomes:

- Look for improved patients with PHQ-9 and GAD-7 scores less than 10 or 5+ point decrease

Patient ID	Clinical Assessment			# of Sessions	Weeks in Tx	Last Follow-Up Contact			Psych. Note
	Date	PHQ-9	GAD-7			Date	PHQ-9	GAD-7	
2300290	11/29/2012	16	11	22	63	1/8/2014	12	11	11/14/2013
2300641	12/27/2013	6	2	2	7	1/28/2014	2	4	
2300472	11/2/2012	17	21	10	67	12/3/2013	26	19	9/6/2013
2300567	8/5/2013	5	4	12	28	2/11/2014	2	1	
2300621	11/18/2013	16	20	1	13				
2300602	11/1/2013	27		4	15	12/10/2013	24		
2300511	1/18/2013	11	19	14	56	11/11/2013	14	17	6/24/2013
2300447	1/17/2013	17	18	10	56	2/4/2014	17	8	7/3/2013
2300645	1/6/2014	10	10	3	6	2/4/2014	2	1	
2300563	7/25/2013	12	10	11	29	2/6/2014	12	8	11/21/2013
2300617	11/13/2013	15	15	4	14	1/2/2014	7		1/9/2014
2300655	1/22/2014	24	19	1	4				
2300193	1/28/2014	24	8	1	3				
2300387	9/20/2012	22	18	33	73	2/18/2014	25	20	11/14/2013

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Current Patient Overview

- Which patients need consultation?
- How do you know?
  - ✓ Patients not improving?
  - ✓ Patients not engaging?
  - ✓ Patients ready for relapse prevention?

Workbook page 10

QUESTIONS?

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Medical leadership for mind, brain and body.

NEXT STEPS

APA SAN OBJECTIVE: TRAIN, READY, CONNECT

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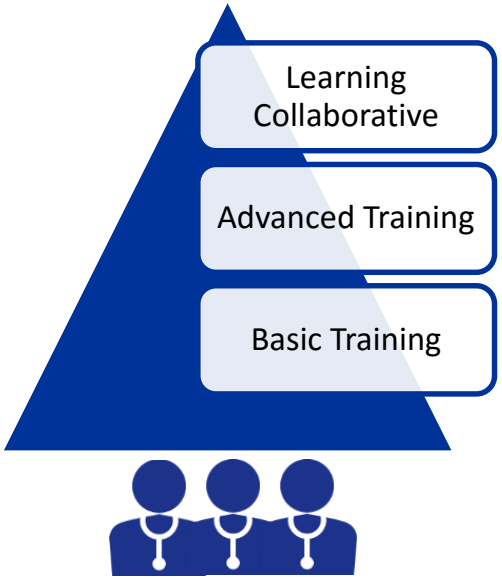
The APA SAN will train 3500 psychiatrists in collaborative care through online and live trainings; offer certificates to those who complete learning collaboratives, and connect trained psychiatrists with PTNs across the country.

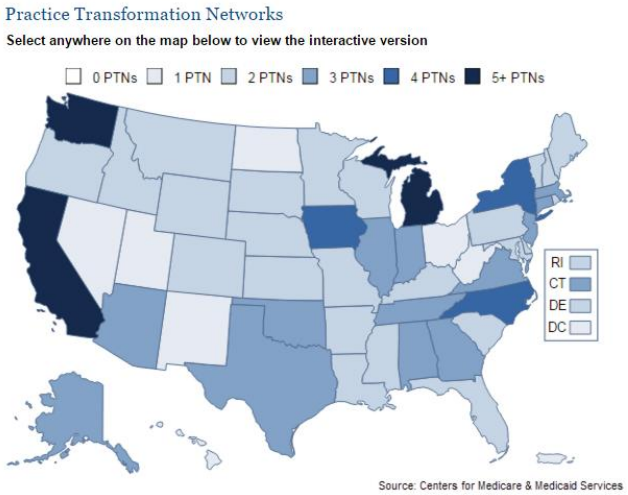
TRAIN



Psychiatrists

READY

CONNECT



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Participate in a virtual Learning Collaborative

- Technical Assistance
- Network
- Apply knowledge in practice settings
- MOC Credit

How to Participate:

1. Indicate that you are interested on your YELLOW form
2. You will receive more information about participating in Learning Collaboratives in late October/early November

GET CONNECTED

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Stay up-to-date on APA's SAN and training offerings at:

www.psychiatry.org/SAN

For more information or questions, email:

SAN@psych.org

QUESTIONS?

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