RN Behavioral Health Care Manager in Primary Care Settings

Integrated Care and the Expanding Role of Nurses

Seattle Airport Marriott, SeaTac, WA
Tuesday, January 9, 2018

The Healthier Washington Practice Transformation Support Hub

Patient Engagement and Evidence-Based Treatment Approaches: Core Skills

Session 3

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Learning Objectives

- List key patient engagement strategies for the RN care manager role.
- Describe different treatment approaches for an RN care manager working with patients with behavioral health conditions.
- Practice introducing your role to a patient and talking about how you would work with a patient with depression in primary care.

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Engaging Patients in Care

Session 3 – Part 1

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Care Managers…

…take ownership of the quality of care and treatment outcomes for all patients engaged in care.

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How Does Treatment Happen in Collaborative Care?

Identify & Engage

Establish a Diagnosis

Initiate Treatment

Follow-up Care & Treat to Target

Complete Treatment & Relapse Prevention

System Level Supports

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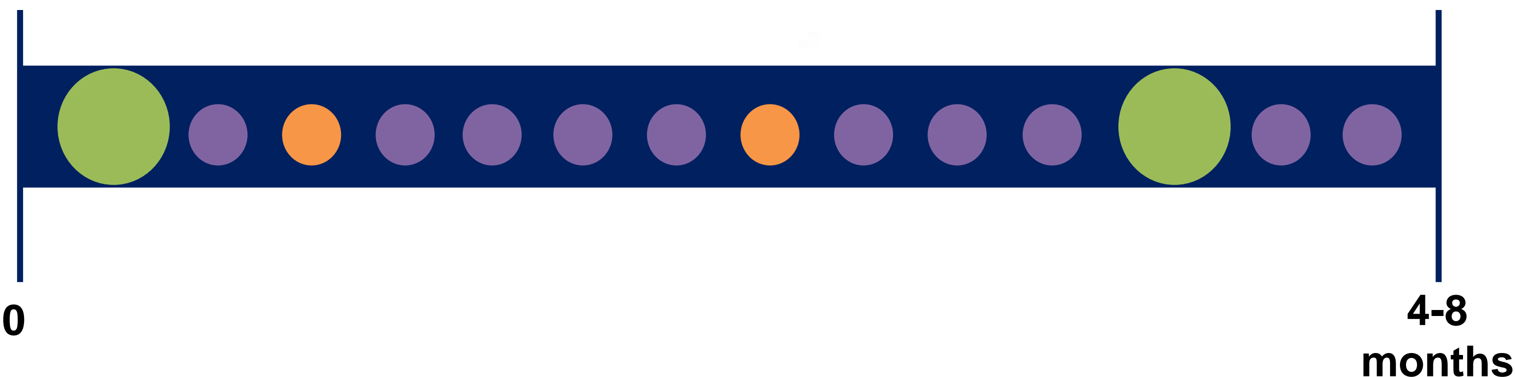
Frequency of Contacts in Collaborative Care Pays Off

= PCP contact (avg. 2 contacts per episode)

= Contacts with CM
(avg. 10 contacts)

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



50% - 70% treatment response/improvement

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Identify and Engage

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Patient Identification

- Initial identification is often done by other members of the team via screeners or clinical presentation
- Your clinic will need a plan for how patients will be identified
  - Are all patients screened?
  - Identified by PCP?
  - Other?
- Early in care, your role is to engage and orient patients to collaborative care

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What the Research Says

- Patients with early follow-up are less likely to drop out and more likely to improve *(Bauer, 2011)*
- Patients who have a second contact in less than a week are more likely to take their medications *(Bauer, 2011)*
- Follow-up contact (phone or in person) within four weeks of the initial assessment key to early improvement *(Bao, 2015)*

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Bao: "Front Loading" Care Management Interventions

No follow-up contact within 4 weeks

≥1 follow-up contacts within 4 weeks

Cumulative proportion of sample

.7
.6
.5
.4
.3
.2
.1
0

0 4 8 12 16 20 24

Weeks to remission or improvement

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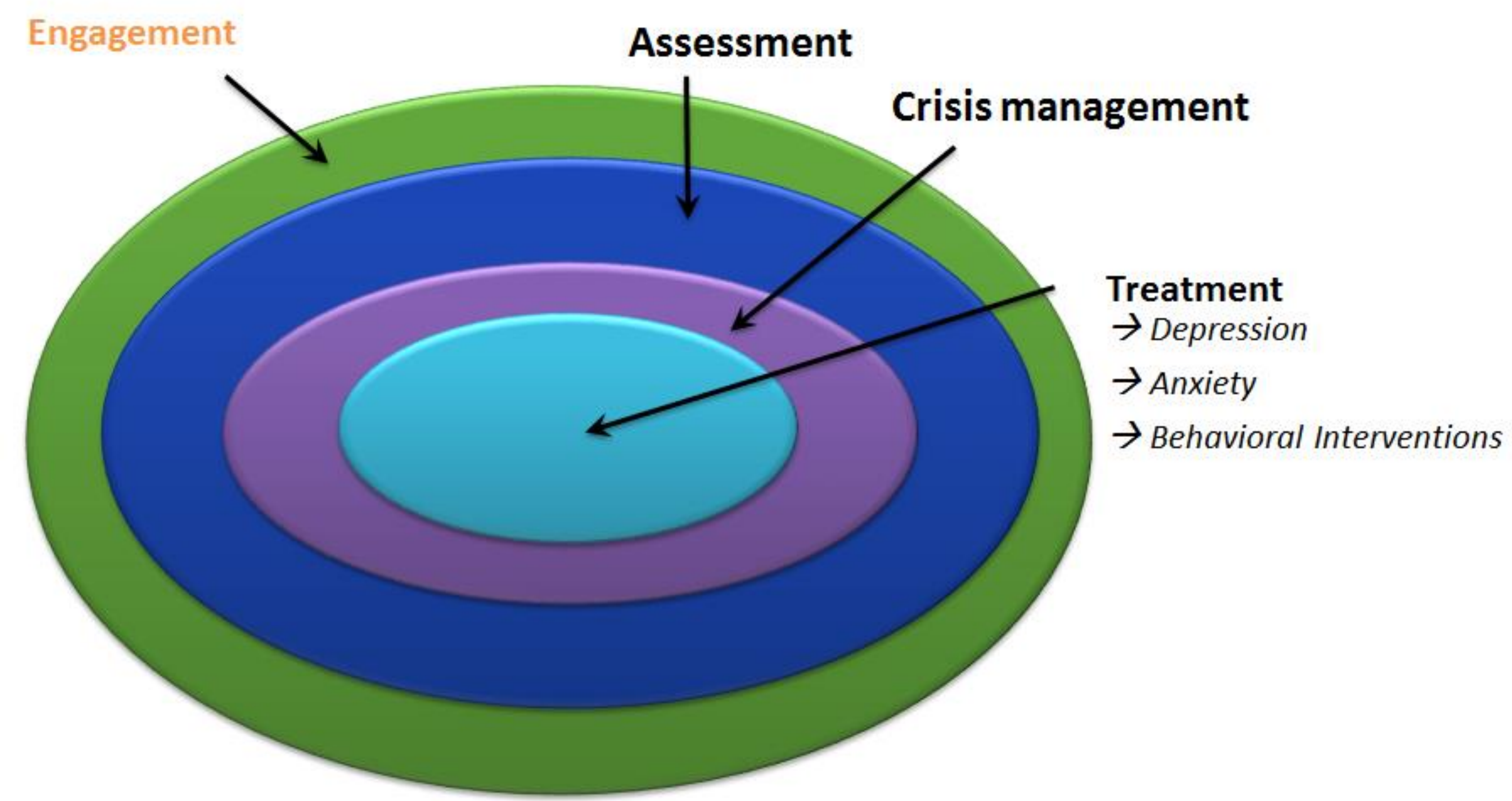
Engagement and the Treatment Process



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Core Engagement Strategies

- All referrals should have a warm connection
  - In person or by phone
- Frequent contact with the patient
  - 2+ contacts in first month
- Patient-centered approach
- Discuss barriers to treatment and develop plan to address them
  - Ability to attend clinic or phone appointments
  - Align with patient's goals

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Connecting Effectively

- Initiate intake during first appointment
  - Do not wait for a longer appointment
- Discuss clinic and phone appointments
  - Gather multiple phone numbers and best time to be reached
- Schedule next phone or in-person contact before patient leaves

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Building Rapport

- Establish goals
- Clarify preferences
- Encourage informed decision-making
- Convey hope
- Reinforce self-management strategies
- Bolster self-efficacy

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Sharing Information

- Clinic provides whole-patient care
- Focus on symptoms that are problematic for patient
  - Don't argue about diagnosis; focus on symptoms
- Treatment options
  - Patient preference
  - Prior experience
  - Family experience

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Set Expectations

- We have effective treatments
- Most patients need at least one treatment change
- We won't give up!
- You play an important role
  - Selecting/changing treatment
  - Goals
  - Self management
  - Family engagement

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Attitudes & Beliefs

- Patients may know little about depression
  - What they do know may be inaccurate
- May believe…
  - Depression is selfish, weakness
  - They should “handle it themselves”
    - Especially true for older adults, men

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Attitudes & Beliefs

- Culture can play important role
  - Cultural beliefs about causes and treatments
  - Stigma
  - Manifestation of symptoms can vary
- Know your own attitudes & beliefs
  - Do you believe psychotherapy is best treatment option for everyone?
  - How do you feel about medications?
- Your beliefs are communicated to patients

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"Minimizer" Patients

- Some patients minimize symptoms/don't endorse depression if asked
  - Could have low PHQ-9 score but obviously depressed
- Older adults and men more likely to minimize or focus on somatic symptoms
- Some cultures are more stoic and more likely to minimize symptoms
- PHQ-9 is a tool to help identify patients
  - It does not replace clinical judgment

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Why Engage Caregivers/Family?

- Family sees mood and behavior changes over time
- Family can support treatment plan, especially self-management plans
- Patient chooses level of family involvement

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How to Engage Caregivers/Family

- Address Family Culture
  - Myths
  - Stigma
  - Beliefs about causes of depression, treatments
- Provide resources to learn about depression
  - http://www.nimh.nih.gov/health/topics/depression/
  - http://www.who.int/campaigns/world-health-day/2017/videos/en/
  - Existing resources in your clinic?
- Share treatment plans
  - Give family role in supporting treatment
  - Engage family in relapse prevention planning

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Structuring Initial Assessment

- Orient patient to structure of initial assessment
  - Assessment is important first step to getting right diagnosis toward getting them the right help
- Start with open-ended question
  - Let patient talk for 3-5 minutes
- Nursing Assessment - Use EHR template to help you track/gather what is needed for diagnosis
  - History of present illness
  - Past psychiatric history (previous episodes or treatment)
  - Social history
  - Functional assessment
  - Few sections are required; use what is clinically useful

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Initial Assessment (Cont’d)

- Reason for seeking health care
- Current medical diagnosis
- History of substance abuse, use
- Ability to remain safe and refrain from harming others

Psychiatric-Mental Health Nursing Review
and Resource Manual, 4th edition

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Phone Use in Treatment

- Discuss phone use with patient at appointment
  - Frequent contact is key for improvement
  - Reduces barriers, i.e. transportation, childcare
  - Phone appointments are scheduled
- Discuss purpose of phone appointments
  - Check-in on medications
  - Complete symptom screeners
  - Work on treatment goals

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Tips for Scheduled Phone Contacts

- Phone contact is considered an appointment
- Block a time in schedule for calls (1–2 hours)
  – 15-20 minutes apart
- Schedule call time with patient
  – Convenient and free from distractions
- Mail or provide a PHQ-9 for ease of use over phone
  – Can ask to complete before the call

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When to Use the Phone

- Missed appointment
  - Call no-shows within 15 minutes
  - Use the time for a phone contact
- Increase contact frequency and strengthen engagement
- Transportation difficulties
- Cannot or does not want to come in
- Children at home
- Check in on patient between in-person visits

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Structure for Phone Contacts

- Ask the patient if it is still a good time
  - Set another time if it is not
- Have no distractions and ask the patient do to the same
- Set agenda
  - Check on PHQ-9, medications, and behavioral activation, PST or other brief therapy session
- Administer the PHQ-9 early in the call
  - Doing so helps to plan for rest of call
- End with plan for next appointment or call

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Persistence is Key!

Don’t give up! Some patients can be hard to reach, but it is critical to be persistent.

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Establish a Diagnosis

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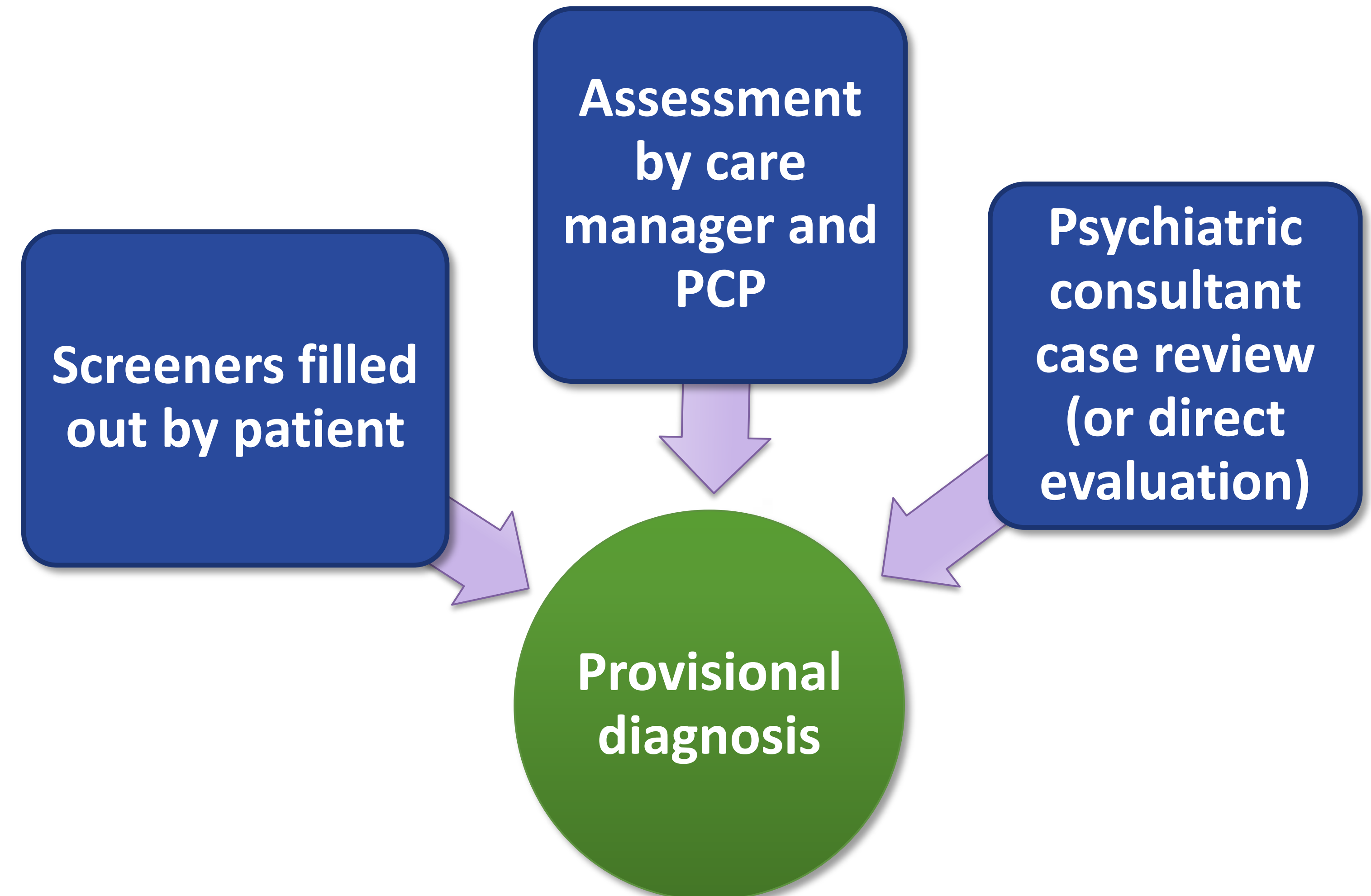
Provisional Diagnosis



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Structured Assessment by the Care Manager

Develop a strategy to systematically collect:

- 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

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Basic Differential DiagnosiS

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

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Example Behavioral Health Measures

- **Depression**
  - PHQ-9
- **Anxiety Scale**
  - GAD-7
- **PTSD Screen**
  - PCL-5
- **Alcohol**
  - AUDIT-C
- **Drug Screen**
  - DAST-1
  - CRAFFT
- **Bipolar**
  - CIDI
  - MDQ

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Advantages of Behavioral Health Measures

- Objective assessment
- Creates common language
- Focuses on function
- Avoids potential stigma of diagnostic terms
- Helps identify patterns of improvement or worsening
- Flexibility of administration

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Initiate Treatment

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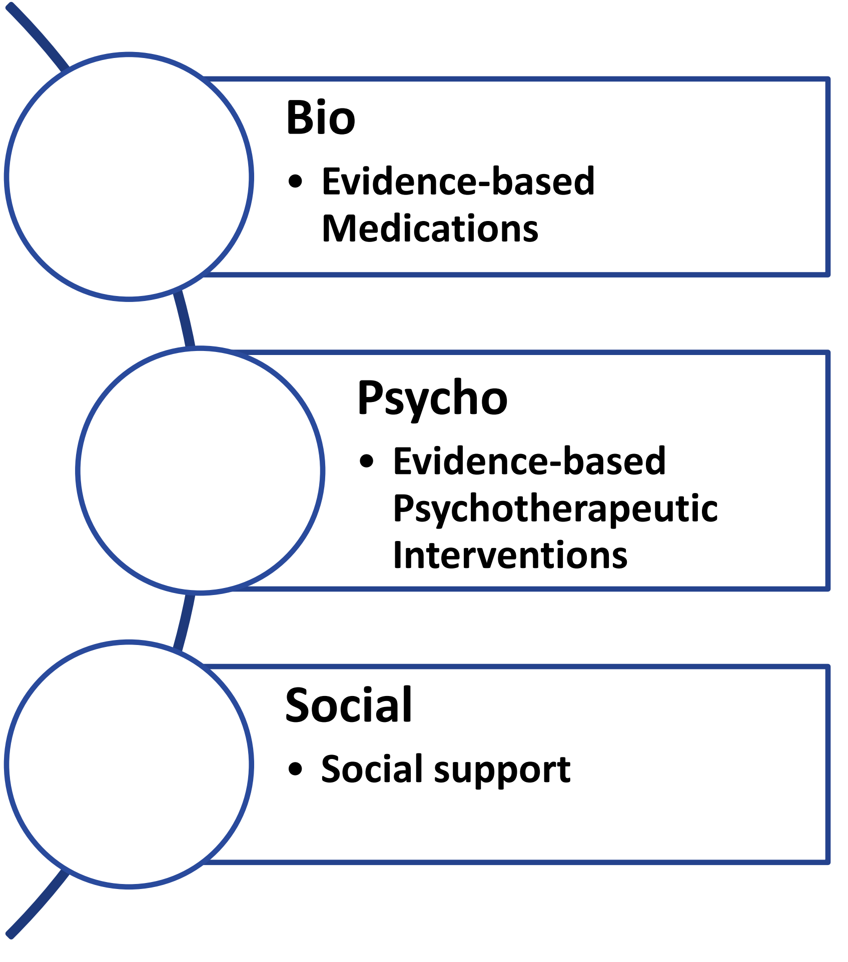
Treatment Options



- *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

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Patient Education: Cycle of Depression

Can use with patients when talking about treatment options

STRESSORS
Medical illness
Family problems
Work problems

THOUGHTS & FEELINGS
Negative thoughts
Low self esteem
Sadness
Hopelessness

DEPRESSION

PHYSICAL PROBLEMS
Poor sleep
Pain
Low energy
Poor concentration

BEHAVIOR
Social withdrawal
Decreased activities
Decreased productivity

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Discussing Treatment Options

- Review all treatment options available
  - Brief behavioral interventions
    - Problem-solving treatment
    - Behavioral activation
    - Cognitive-behavioral treatment
    - Key is that it is evidence-based!
  - Medications
- This discussion is critical in case you need to add a treatment later if patient isn't progressing
- Discuss pros and cons of each option
  - Allows patient to make an informed choice

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Discussing Treatment Options

- The treatment that works is the best one
  - Patient-centered care means patient selects treatments, not clinician preference
    - Try to be unbiased when offering treatment options
- Supporting whole person treatment is important- “One size fits few”
  - Medication is not right for everyone
    - You can support medication therapy within scope of practice
  - Psychotherapy is not right for everyone

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Practice: Introducing Depression to a Patient

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Evidence-based Brief Behavioral Interventions

Examples include:

- Problem-solving treatment (PST)
- Behavioral activation (BA)
- Cognitive behavioral therapy (CBT)
- Brief interpersonal therapy (IPT)

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Example of Explaining Behavioral Interventions

Medications

Feel Bad

Do Less

Brief Behavioral Interventions

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Problem-Solving Treatment (PST)

FAST

- Engage patient in what they care most about

FOCUS ATTENTION

- Training brain to solve problems

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Problem-Solving Process

UNIVERSE OF PROBLEMS

Problem Definition

Realistic Patient Goal

Brainstorming

Pros and Cons

Choosing a Solution

Action Plan

Outcome Evaluation

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Behavioral Activation

Behavioral Activation (BA) is a powerful intervention

- Interrupts cycle of depression and anxiety
- Increases patient empowerment
- It feels good: a little bit can go a long way

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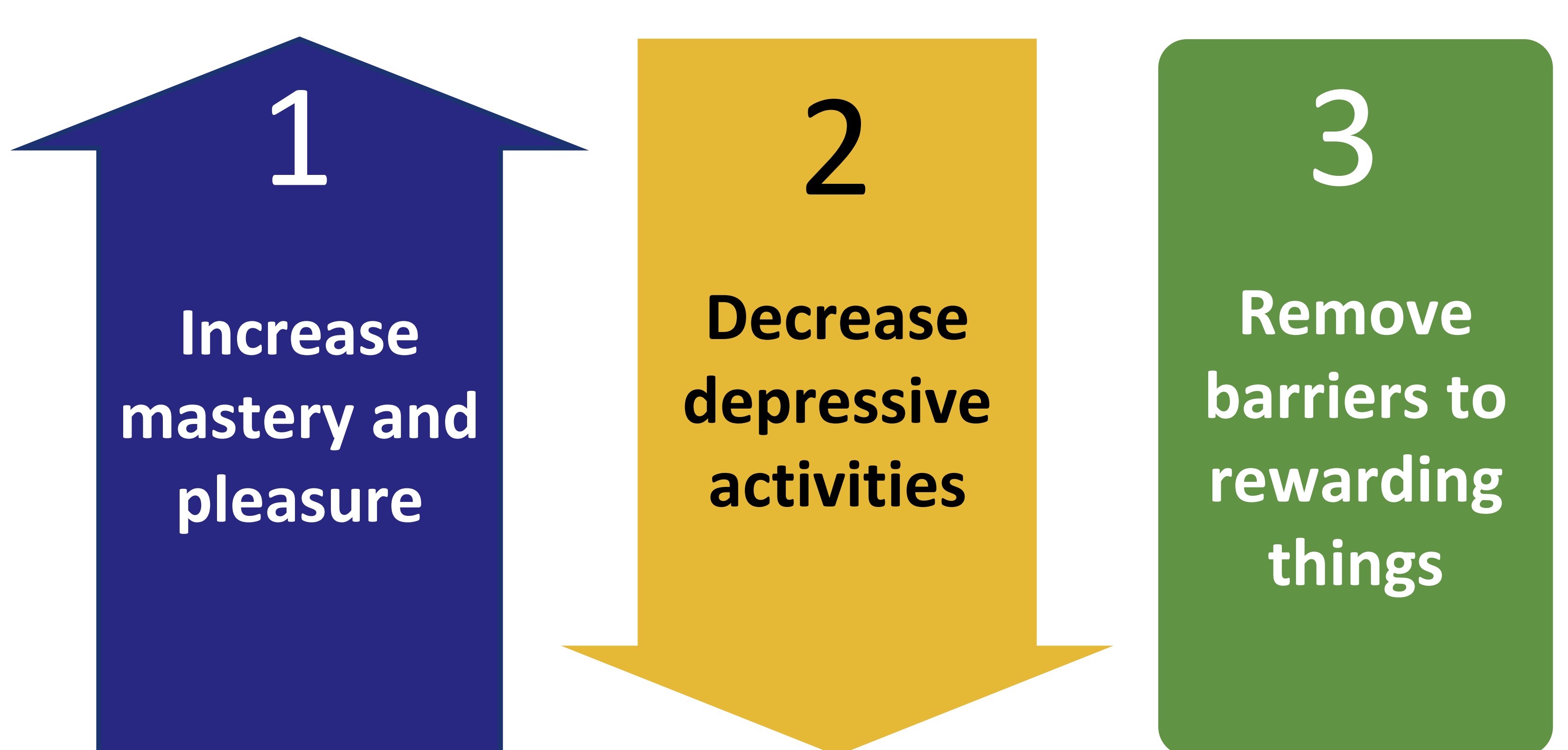
Three Goals of Behavioral Activation



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Maximizing Activation: Simple But Powerful

Goals

- Re-establish routines
- Distract from problems or unpleasant events
- Increase positively reinforcing experiences
- Reduce avoidant patterns
- Increase critical thinking
- Decrease negative emotional response to activity

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Maximizing Activation

Approach: Outside → In

Typically we think of acting from the "inside → out"

(e.g., we wait to feel motivated before completing tasks)

In BA, we ask people to act according to a plan or goal rather than a feeling or internal state

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Why Do Care Managers Need to Know About Medication Use?

- Role of supporting successful medication treatment:
  - Missed opportunities to support adherence in present-day treatment as usual
  - Adherence is a big deal
    - Actual real-life medication adherence probably less than 50%!
- Familiarity with the reasons why medication trials fail
- Management of common benign side effects can facilitate adherence

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Ongoing Learning is the Core Task

- The medication knowledge base is massive
- MEMORY IS TREACHEROUS!
- The key is to know where to find:
  - – Good information
  - – In useful form
  - – Quickly

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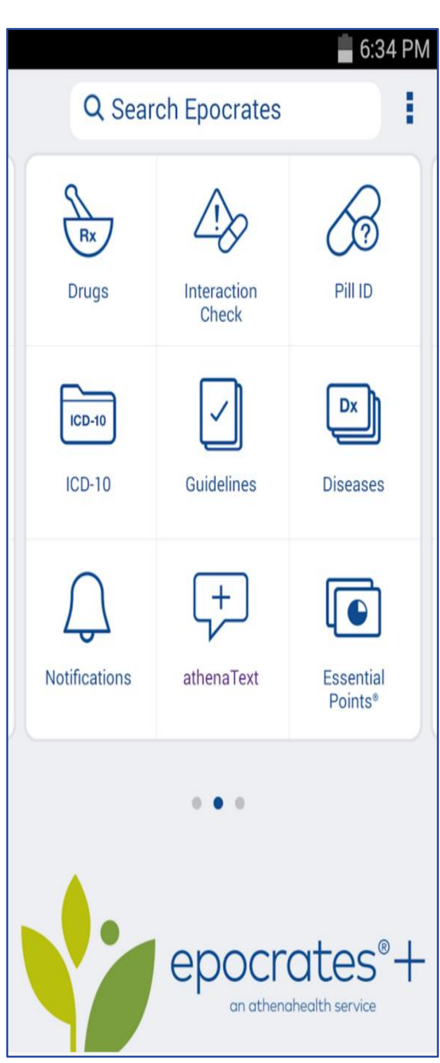
Good Information Sources

- Epocrates
  - Excellent up-to-date information on phone app or desktop
- AIMS Center resources
  - Commonly prescribed psychotropic Medications
- Your psychiatric consultant!



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Role of Care Manager Re: Medications

- Gathering history
- Coordinating with PCP
  - Why did they suggest that?
- Recognizing common problems
  - Patient starts medication for the first time
  - What to do when the dose isn't working
  - What to do when you (BHC/care manager) doesn't know the answer
- Supporting treatment adherence
  - The art of the elevator speech:
    - The 2-wk appointment speech
    - How does this help when I have so many problems?

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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 seizu[illegible]sorder because it decreases seizure threshold; **stimulating; not good for treating anxiety disorders;** second line TX for ADHD; abu[illegible]ntial. ¢ (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 S[illegible]ew 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 [illegible]s; 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 p[illegible] Celexa).	Best tole[illegible]ew 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/d.	More [illegible]RIs; long half-life reduces withdrawal (t ½ = 4-6 d). ¢
Mirtazapine (Remeron)	Start: 15 mg qhs. X 4[illegible] then ↑ to 30 mg qhs. Range: 30-60 mg/qhs.	S[illegible]ng. Neutropenia risk (1 in[illegible]) so avoid in immunosupressed patients. ¢
Paroxetine (Paxil)	Start: 10 mg qhs X 4-7[illegible]20 mg qday. Range: 20-60 mg/d.	[illegible]nificant withdraw[illegible]e. ¢
Sertraline (Zoloft)	Start: 25 mg qam X 4-7[illegible]day. Range: 50-200 m[illegible]	[illegible]eractions: [illegible] ¢
Venlafaxine (Effexor)	Start: IR-37.5 mg bid X 4[illegible]-75 mg qam X[illegible] Range: 150-375 mg/d.	[illegible]pathic pain above 150 mg qday; **need to monitor BP**; 2nd line tx for ADHD. Significant
*Warnings/precautions: 1) Potential increased suicidality in fir[illegible] SSRIs and SNRIs), Increased risk of bleeding with SSRIs and S[illegible]		[illegible]occurs with abrupt cessation (especially with [illegible]emia sometimes seen with SSRIs and SNRIs.
[illegible]		
Alprazolam (Xanax)		[illegible]e addictive than other benzos and has uniquely problematic withdrawal
Chlordiazepoxide (Librium)		[illegible]1/2: 10-48 hrs (parent compound), 14-95 hrs (metabolites). Useful for treating
Clonazepam (Klonopin)	Start: [illegible]	[illegible]60 hrs. Helpful in tx mania. ¢
Diazepam (Valium)	Start: 2–10[illegible] mg/d.	[illegible]0 hrs. Note: the presence of liver disease will significantly lengthen half-life. ¢
Lorazepam (Ativan)		[illegible]: No active metabolites, so safer in liver dz. ¢
Buspirone [illegible]		[illegible]. May take 4-6 weeks to become fully effective. ¢
Hydroxyz[illegible]		[illegible]. Consider in pts w/ hx of substance abuse. ¢
Prazosin (Minipress)		[illegible]s d/t PTSD. Need to warn about orthostasis particularly in AM after first dose and
Trazodone (Desyrel)	[illegible]	[illegible]inform abou[illegible] ¢
Temazepam (Restoril)	Start: 1[illegible]	[illegible]notic. No P450 metabolism. [illegible]tial for physical dependence than Ambien/Sonata. ¢
Zolpidem (Ambien)	Start: [illegible]	[illegible]eating and sleep-driving. ¢ Available in longer acting form (CR $)
[illegible]d Stabiliz[illegible]		
Lithium	[illegible] (usu[illegible] Lithobid & Eskalith). Plas[illegible]	[illegible]ack box warning for toxic[illegible]. Teratogenic (cardiac malform.) and will **need to inform women of childbearing age of this risk**. Check [illegible]SH and BMP before starting and q 6-12 months thereafter. Advise pt about concurrent use of NSAIDS and HTN meds as can decrease renal clearance. Lithium strongly anti-suicidal. ¢, (lithium carbonate, citrate & SR), $ (Lithobid, Eskalith)
Divalproex (Depakote)	Start: 750 mg daily (bid o[illegible]crease do[illegible]y as tolerated to clinical effect. Target pla[illegible]0 mcg/mL (DR) [illegible]125 mcg/ml (ER).	**Multiple black box warnings** including for hepatotoxicity, pancreatitis, and teratogenicity (**need to inform women of childbearing age of this risk**). Need to monitor LFTs, platelet counts, and coags initially and q3-6 mo. Significant weight gain common. $
Lamotrigine (Lamictal)	Start: 25 mg daily for wee[illegible]50 mg daily for weeks 3 & 4, then 100 mg qday for week 5, and finally 200 m[illegible]week 6+ (usual target dose). Dosage will need to be adjusted for patients takin[illegible]yme-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.

Cheat Sheet!

- Basic Education
- Names and Doses
- Side Effects

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Not Just Medications

Psychiatric consultant can help:

- Clarify diagnosis
- Suggest psychotherapeutic interventions
- Brainstorm strategies when patient is not improving
- Provide emotional support to care manager

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A Collaborative Care Plan

- Shared by the whole team
  - Where will everyone be able to see it?
- Include all treatment options
  - Behavioral interventions, medications, referrals
- Clear goals and roles
  - A prioritized list, especially for complex patients
  - A clear “owner” for tracking goals

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Case

- 57-year-old Caucasian male
  - “Difficulty falling asleep, drinks 10 cups of coffee a day, fecal incontinence, and feeling run down”
  - Diabetes
  - PHQ-9 score is 16
  - GAD-7 score is 14. ruminating thoughts

→ Discuss behavioral activation plans for this patient.

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