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
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.
Engaging Patients in Care

Session 3 – Part 1
Care Managers...

...take ownership of the quality of care and treatment outcomes for all patients engaged in care.
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
Frequency of Contacts in Collaborative Care Pays Off

- Green circle: PCP contact (avg. 2 contacts per episode)
- Purple circle: Contacts with CM (avg. 10 contacts)
- Orange circle: Case reviews from psychiatric consultant to CM, PCP (avg. ~2 case reviews)

50% - 70% treatment response/improvement
Identify and Engage

Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention

System Level Supports
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
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)
Bao: “Front Loading” Care Management Interventions

The graph shows the cumulative proportion of sample over weeks to remission or improvement, comparing two conditions: no follow-up contact within 4 weeks and ≥1 follow-up contacts within 4 weeks.
Engagement and the Treatment Process

- Engagement
- Assessment
- Crisis management

Treatment:
- Depression
- Anxiety
- Behavioral Interventions

Used with permission from the University of Washington AIMS Center
Copyright © 2017 University of Washington
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
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
Building Rapport

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

Used with permission from the University of Washington AIMS Center

Copyright © 2017 University of Washington
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
How to Engage Caregivers/Family

• Address Family Culture
  – Myths
  – Stigma
  – Beliefs about causes of depression, treatments

• Provide resources to learn about depression
  – Existing resources in your clinic?

• Share treatment plans
  – Give family role in supporting treatment
  – Engage family in relapse prevention planning
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
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
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
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
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
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
Persistence is Key!

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

- Screeners filled out by patient
- Assessment by care manager and PCP
- Psychiatric consultant case review (or direct evaluation)
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
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
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
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
Initiate Treatment

System Level Supports

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention
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
Patient Education: Cycle of Depression

Can use with patients when talking about treatment options
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
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
Practice:
Introducing Depression to a Patient
Evidence-based Brief Behavioral Interventions

Examples include:

– Problem-solving treatment (PST)
– Behavioral activation (BA)
– Cognitive behavioral therapy (CBT)
– Brief interpersonal therapy (IPT)
Example of Explaining Behavioral Interventions

Feel Bad → Do Less → Brief Behavioral Interventions → Medications → Feel Bad

Used with permission from the University of Washington AIMS Center
Copyright © 2017 University of Washington
Problem-Solving Treatment (PST)

UNIVERSE OF PROBLEMS

YOU ARE FIRED

FAST

• Engage patient in what they care most about

FOCUS ATTENTION

• Training brain to solve problems
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
Three Goals of Behavioral Activation

1. Increase mastery and pleasure
2. Decrease depressive activities
3. Remove barriers to rewarding things
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
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.

Approach: Outside → In
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
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
Good Information Sources

• Epocrates
  – Excellent up-to-date information on phone app or desktop

• AIMS Center resources
  – Commonly prescribed psychotropic Medications

• Your psychiatric consultant!
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?
Cheat Sheet!

- Basic Education
- Names and Doses
- Side Effects
Psychiatric consultant can help:

- Clarify diagnosis
- Suggest psychotherapeutic interventions
- Brainstorm strategies when patient is not improving
- Provide emotional support to care manager
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
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.
The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.