Working in Primary Care Settings: How can I communicate effectively with PCPs?

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Speaker Disclosures

- Dr. Kern has no disclosures to make.

Learning Objectives

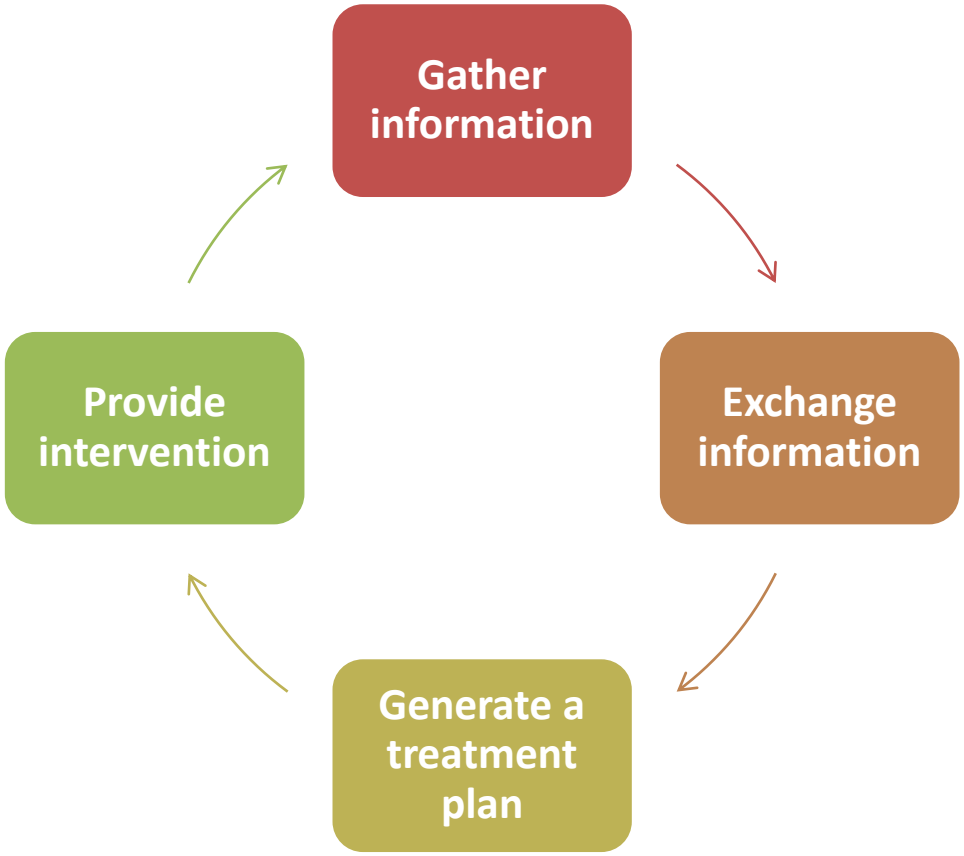
At the conclusion of this presentation, the learner will be able to:

1. Describe the central role of the primary care provider in the collaborative care team.
2. List three strategies to improve the effectiveness of communication with your primary care provider partner.

Why the PCP is important

- PCP recommendation is powerful
  - Introduce care manager and team roles
- Existing relationship is foundation for alliance with the Collaborative Care team

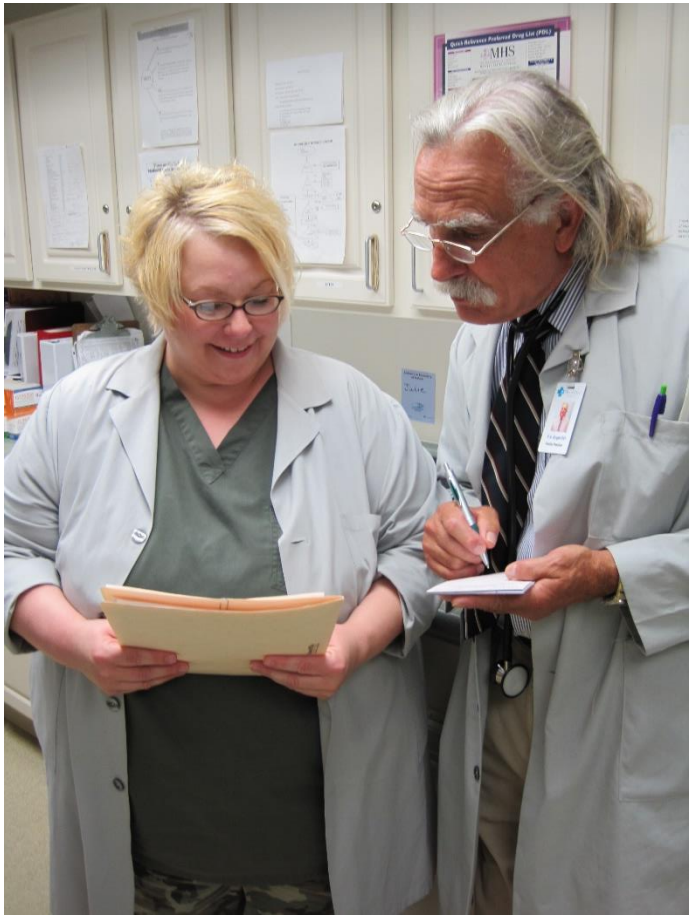
PCP Role: Diagnosis



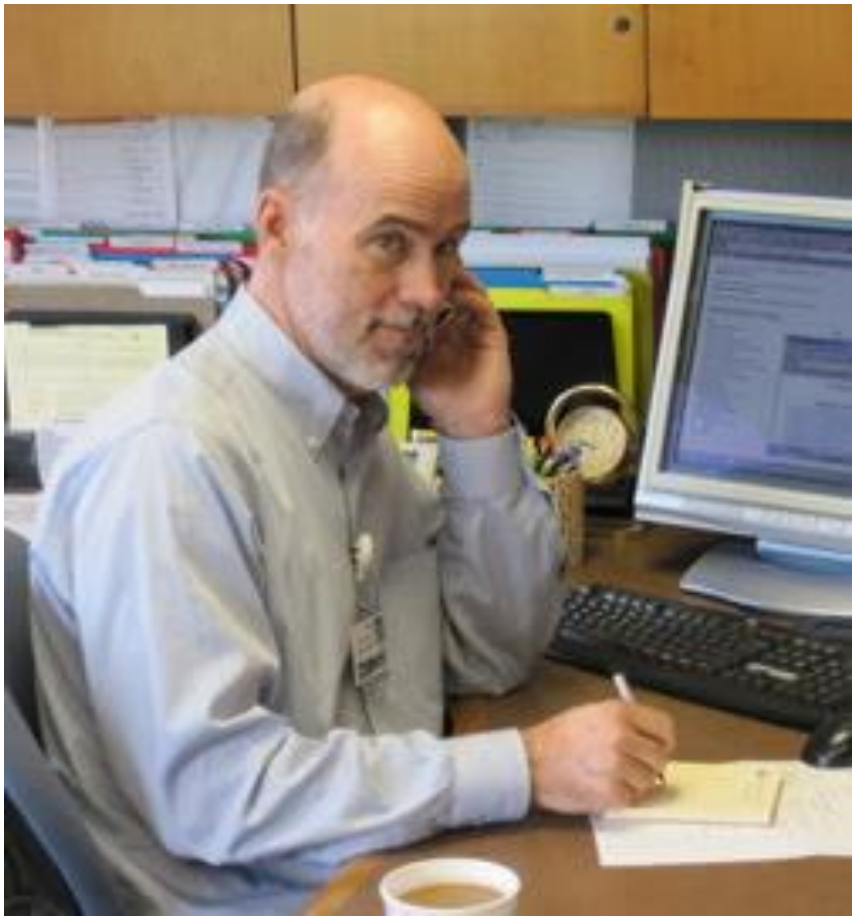
- PCP may have long history with patient

Engaging the PCP: “Why am I doing this?”

- These patients are already your patients.
- They are not going away.
- We can help with everyday workflow, shorten long appointments, reduce arguments about controlled substances… We have your back!
- Can help with chronic disease outcomes, IMPROVE YOUR METRICS!



Making yourself indispensable

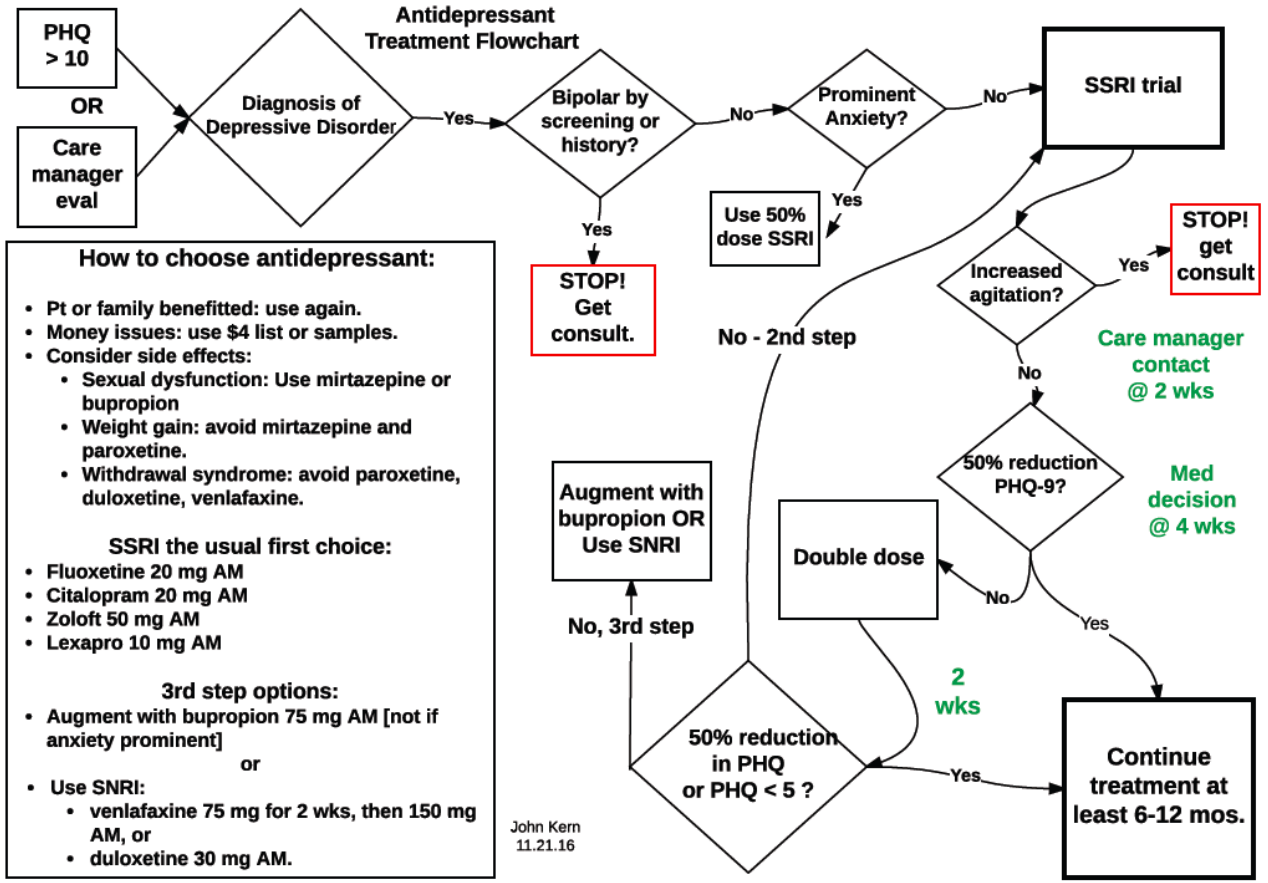


- Respond to “extra” requests
- Make sure you are “interruptible”
- Point out that you can respond to patients that take large amounts of PCP time. Help them develop the skill of quick and effective referral.

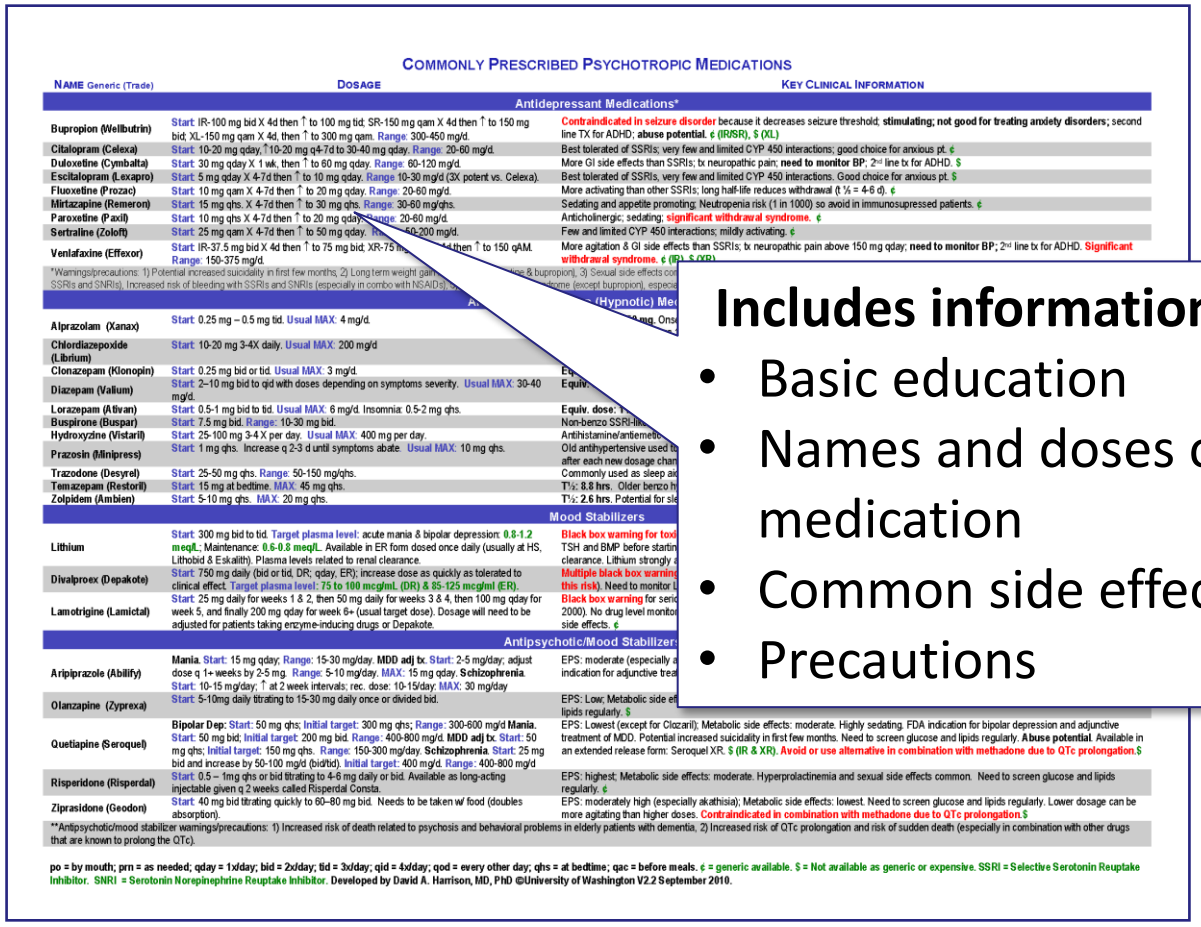
Making yourself indispensable some examples:

- Treatment protocols – an evolving toolkit
  - Medication info
  - Depression
  - ADHD
  - Bipolar
  - Sleep
  - Smoking, other behavior change
- Practical help with managing difficult patients
  - Benzos
  - Pain
  - Suicide risk
  - MAT?

Example of how to come bearing gifts: antidepressant protocol



Prescribing Cheat Sheet



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: 60-120 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 mg/d (3X potent 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/d.	More activating than other SSRIs; long half-life reduces withdrawal (t ½ = 4-6 d). ¢
Mirtazapine (Remeron)	Start: 15 mg qhs. X 4-7d then ↑ to 30 mg qhs. Range: 30-60 mg/qhs.	Sedating and appetite promoting; Neutropenia risk (1 in 1000) so avoid in immunosupressed patients. ¢
Paroxetine (Paxil)	Start: 10 mg qhs X 4-7d then ↑ to 20 mg qday. Range: 20-60 mg/d.	Anticholinergic; sedating; significant withdrawal syndrome. ¢
Sertraline (Zoloft)	Start: 25 mg qam X 4-7d then ↑ to 50 mg qday. Ra… 50-200 mg/d.	Few and limited CYP 450 interactions; mildly activating. ¢
Venlafaxine (Effexor)	Start: IR-37.5 mg bid X 4d then ↑ to 75 mg bid; XR-75 m… 4 then ↑ to 150 qAM. Range: 150-375 mg/d.	More agitation & GI side effects than SSRIs; tx neuropathic pain above 150 mg qday; need to monitor BP; 2nd line tx for ADHD. Significant withdrawal syndrome. ¢ (IR), $ (XR)
*Warnings/precautions: 1) Potential increased suicidality in first few months; 2) Long term weight gain … & bupropion), 3) Sexual side effects co… SSRIs and SNRIs). Increased risk of bleeding with SSRIs and SNRIs (especially in combo with NSAIDs)… drome (except bupropion), especia…		
A… (Hypnotic) Me…		
Alprazolam (Xanax)	Start: 0.25 mg – 0.5 mg tid. Usual MAX: 4 mg/d.	…mg. Ons…
Chlordiazepoxide (Librium)	Start: 10-20 mg 3-4X daily. Usual MAX: 200 mg/d	
Clonazepam (Klonopin)	Start: 0.25 mg bid or tid. Usual MAX: 3 mg/d.	Eq…
Diazepam (Valium)	Start: 2–10 mg bid to qid with doses depending on symptoms severity. Usual MAX: 30-40 mg/d.	Equiv…
Lorazepam (Ativan)	Start: 0.5-1 mg bid to tid. Usual MAX: 6 mg/d. Insomnia: 0.5-2 mg qhs.	Equiv. dose: …
Buspirone (Buspar)	Start: 7.5 mg bid. Range: 10-30 mg bid.	Non-benzo SSRI-like…
Hydroxyzine (Vistaril)	Start: 25-100 mg 3-4 X per day. Usual MAX: 400 mg per day.	Antihistamine/antiemetic…
Prazosin (Minipress)	Start: 1 mg qhs. Increase q 2-3 d until symptoms abate. Usual MAX: 10 mg qhs.	Old antihypertensive used t… after each new dosage chan…
Trazodone (Desyrel)	Start: 25-50 mg qhs. Range: 50-150 mg/qhs.	Commonly used as sleep ai…
Temazepam (Restoril)	Start: 15 mg at bedtime. MAX: 45 mg qhs.	T½: 8.8 hrs. Older benzo h…
Zolpidem (Ambien)	Start: 5-10 mg qhs. MAX: 20 mg qhs.	T½: 2.6 hrs. Potential for sle…
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 toxi… TSH and BMP before startin… clearance. Lithium strongly …
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 warning… this risk). Need to monitor L…
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 seric… 2000). No drug level monito… side effects. ¢
Antipsychotic/Mood Stabilizer…		
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 a… indication for adjunctive trea…
Olanzapine (Zyprexa)	Start: 5-10mg daily titrating to 15-30 mg daily once or divided bid.	EPS: Low; Metabolic side ef… 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.

Includes information such as:

- Basic education
- Names and doses of medication
- Common side effects
- Precautions

https://aims.uw.edu/sites/default/files/Psychotropics%20Medications_2018.pdf

Bipolar Roadmap

Bipolar Management Roadmap

Diagnosis
History, including prior treatment
MDQ, then CIDI if positive

Care Manager Consultation -
Confirm diagnosis
Is specialty care needed?
Consult with psychiatrist before making diagnosis, or changing treatment.
Give Information Packet;
- Diagnosis
- Medication Info
- Mood Charting
- Rhythm / self-management / sleep hygiene

Arrange aftercare
No more than 2 wks with new of changed meds
No more than 3 months ever
Call for no show
Follow mood charts.

How to choose mood stabilizer:
- If antidepressant on board, discontinue.
- Lithium first line. Usually Depakote 2nd, Tegretol 3rd.
- If psychotic - atypical
- If depressed: Lamictal / Latuda / Seroquel
- Not unusual to need more than one mood stabilizer.

Lithium:
Start 300-600 mg hs, titrate to response weekly and to level ~0.7.
Lab monitoring:
- Baseline TSH, BMP, Lithium level at one week with each change, then q 6 mos with BMP when stable.
- TSH yearly

Side effect mgmt:
- Tremor [lower dose or add prpranolol 20 mg prn.
- GI upset (divide dose, take with food.)
- Loose stools, acne, wt gain, polyria.
- Serious but rare: renal insufficiency.

Valproate
Start 20 mg/kg/day = weight in lbs x 10 rounded to 500 mg. HS dosing
Laboratory monitoring:
- CBC, CMP baseline, at one month
- Levels at one month, with dosage change, lack of efficacy. Target level: 50-120 Titrate to effectiveness.

Side effect management:
- Weight gain - dietary management
- Tremor - beta-blocker GI distress - hs dose Risk of PCOS - avoid in young women, rash Serious but rare: Hepatotoxicity [minor increase in LFT's is not unusual], encephalopathy, Pancreatitis, bone marrow d/o

Carbamazepine:
200 mg BID x 2 wks, then increase by increments of 200 mg per day as tolerated.
Laboratory monitoring:
- level at one month, 3 months, with dosage change, lack of efficacy, side effects, watch for induction Target levels 4-12, cbc & cmp at one month

Side effect management:
- Ataxia - reduce dose Hyponatremia - monitor, discontinue below Na 125.
- Rash Serious but rare: Stevens-Johnson syndrome Bone marrow disorders

Lamictal
Titrate per instructions: 25 mg daily x 2 wks, then 50 mg daily x 2 wk, then 100 mg daily. If on Depakote, 25 mg every other day x 2 wks, then 50 mg. May not need more than 25-50 mg.
If on Tegretol, 50 mg daily x 2 wks, then 100 mg daily
Labs - not recommended
Side effect management:

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Exercise 1

In the break room at your new clinic, you are introduced for the first time to a PCP with whom you will be working. She says, “Nice to meet you. I have five minutes until my next patient. What’s up with this Collaborative Care thing?”

- What are three things you could say to help build your working relationship?
  - Explaining your role
  - How Collaborative Care is different from treatment as usual in primary care
  - How can you be useful to them

How the psychiatrist leads the team:

- Training and shaping care manager practice over team.
- Advocating for the program with administration.
- Improving practice via attention to data, quality improvement.
- Framing the significance of the team's function – they don't know that they work at the cutting edge, they are just going to work.
- Point out all the advantages to psychiatry in primary care
  - Urgent access
  - Lab monitoring
  - Systematic approach to care

Takeaways

1. *PCP engagement crucial to a successful Collaborative Care program.*
2. *Understanding needs and constraints of PCP goes a long way to engagement.*
3. *Ongoing curiosity about how to be more helpful to your PCP partner will inspire your creativity.*

Resources

- AIMS Center office hours
- UW PACC
- Psychiatry Consultation Line
  - (877) 927-7924
- Partnership Access Line (PAL)
  - (866) 599-7257
- PAL for Moms
  - (877) 725-4666

Questions and Discussion

- Ask questions in the chat or unmute yourself

Registration

- If you have not yet registered, please email uwictp@uw.edu and we will send you a link