Interdisciplinary Management of Psychiatric Patients in Primary Care

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DISCLOSURE STATEMENT

Disclosure Statement: We do not have any financial interests or affiliation concerning the material discussed in this presentation.

LEARNING OBJECTIVES

- Identification of common psychiatric problems in primary care
- Assessment of psychiatric patient in primary care
- Collaboration of psychiatric patient in primary care
- Treatment of psychiatric patient in primary care
- Evaluation of treatment of psychiatric patient in primary care

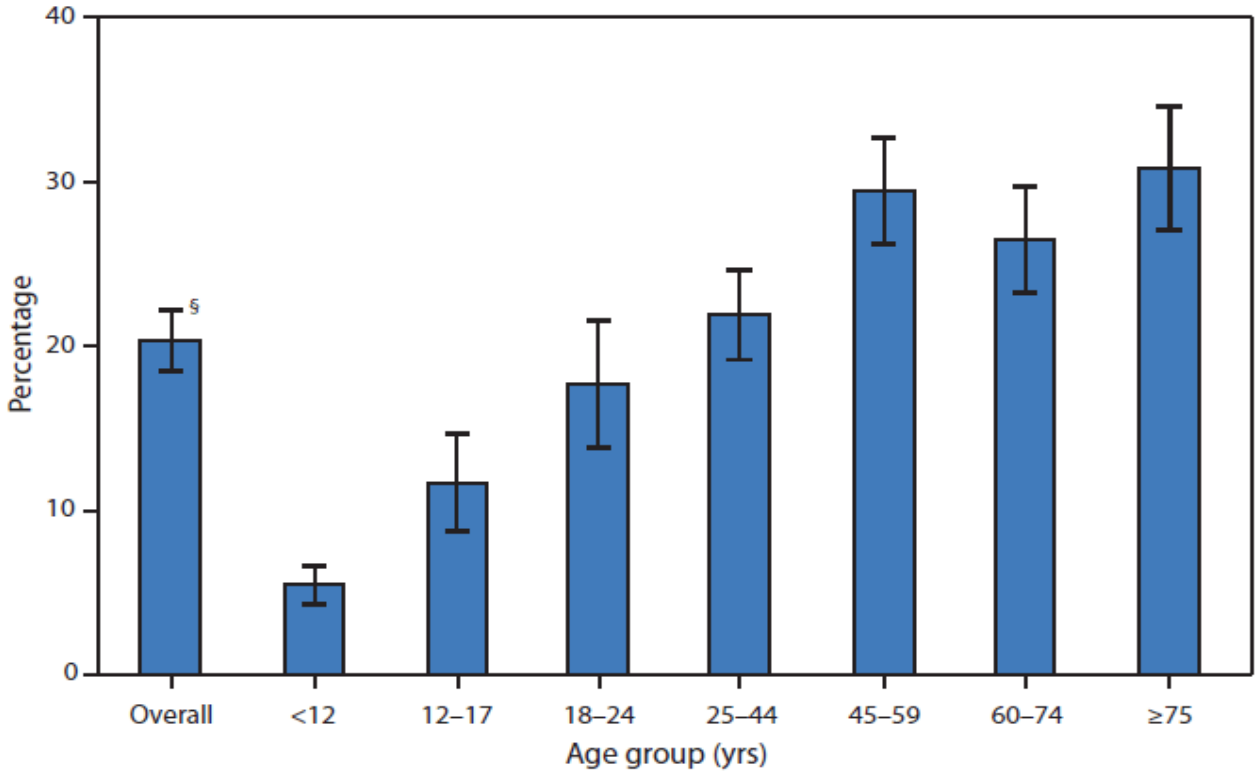
PSYCHIATRIC PATIENTS IN PRIMARY CARE

- Why does it matter?
- Primary care providers prescribe 79% of all antidepressants in the United States
- Primary care providers are the gatekeepers and the safety net for scarce mental health resources
- Access to care, affordability, timely treatment are key in appropriate management of psychiatric disorders-primary care providers are an important link in the chain for patient care.

COMMON PSYCHIATRIC PROBLEMS IN PRIMARY CARE

- Depression
- Anxiety
- ADD/ADHD
- Adjustment disorders
- Neurocognitive disorders
- Bipolar
- Sexual dysfunction(s)

PREVALENCE OF MENTAL HEALTH DISORDERS IN PRIMARY CARE



Source: CDC, Morbidity and Mortality Weekly Report, 2022

PCP/NP AS GATEKEEPERS

- Psychiatric illnesses frequently present as somatic complaints.
- Patients may not be forthcoming in stating their psychiatric distress and symptoms, and frequently may cite a physical ailment when the true issue is psychiatric in origin
- Primary care providers are the gatekeepers and front line clinicians who are ideally poised to ensure an accurate diagnosis, and subsequent appropriate treatment and referrals as warranted

ASSESSMENT

- Identify patients with validated screening tools
- (PHQ-9, Hamilton, MOCA, Mini-Mental, etc)
- Assess safety of patient (and caregivers). Is the patient safe? Is the caregiver(s) safe to be treated by PCP or does an urgent referral need to be initiated?
- Comprehensive evaluation with screening tools, speaking to patient, caregivers, assessing home situation and support

CONDITIONS TO CONSIDER REFERRAL TO PSYCHIATRIC COLLEAGUES

- Refer based upon severity/functional impairment rather than diagnosis:
- History of psychiatric hospitalization
- History of self-harm or current suicidal ideation

CONDITIONS TO CONSIDER REFERRAL CONTINUED…

- History of failure of multiple psychiatric treatments
- Active substance use disorder
- Multi-system involved clients, e.g., social services, courts, school system
- Current or foreseeable legal involvement (unless you like that sort of thing)

EVALUATION OF PSYCHIATRIC PATIENT IN PRIMARY CARE

- Always begin directly with safety: suicidality, homicidality, safety (domestic violence/child/elder endangerment), SUBSTANCE USE
- Current level of functioning: “How do you spend your time?”
- Determine markers of progress: “What would you do if you weren’t struggling with this?”
- Directly ask about sleep, appetite, energy, thoughts that bother them, hearing voices, seeing things, believing things others do not
- “Is there anything else I need to know to help you?”

EVALUATION CONTINUED…

- The fastest route to therapeutic misadventure is to miss substance use
- Assessment compounded by societal judgment, clinician distaste, specter of legal issues
- Two approaches to questions to avoid being perceived as judgmental
- “Which drugs or alcohol have you tried to make this better?”
- OR “These are questions I ask all my clients: Which drugs have you used and what do you drink?”

COLLABORATION OF PSYCHIATRIC PATIENTS

- PCP to investigate and determine any iatrogenic causes of behavioral issues
- Examples: Hypothyroidism, infections, elevated ammonia levels, pain, etc.
- Communicate results of workup to psychiatric colleagues

COLLABORATIVE CASE STUDY

- Your 19yo long-term client with Type I diabetes presents with his mother. He is distracted, talking to himself, disheveled.

- Client returns in six weeks, but you cannot recognize him: he's gained 30 pounds. Prescribed Zyprexa and Depakote for a diagnosis of schizoaffective disorder. No labs on file

- DISCUSS!

TREATMENT OF PSYCHIATRIC PATIENTS IN PRIMARY CARE

- Make sure you have an accurate story: deputize collaterals with client consent
- Request records
- “What’s the number one thing you want to change with psychiatric medication (about how you think, feel, or act)?”

TREATMENT OF PSYCHIATRIC PATIENTS CONTINUED…

- “What worked for you previously, and in what way?”
- “What didn’t work for you previously, and in what way?”
- “What did/didn’t work for blood relatives?”
- Start low, go slow, check in frequently to assess for toxicity (behavioral & metabolic)

ROADBLOCKS/ISSUES

- Scarcity of psychiatric resources
- Limitation of insurance panel providers
- No insurance/self-pay patients
- Delay in being seen and evaluated
- Lack of communication from PCP to specialist and vice versa

CONCLUSION

- Primary Care Providers see a large amount of psychiatric patients
- NP's are the gatekeepers and safety net for psychiatric patients

- Somatic complaints may frequently present as the chief complaint, but a psychiatric issue is the true issue

- Collaborate and use your contacts: Make friends with psychiatry friends in the community! Send them cookies! Remember their birthday!

THANK YOU FOR COMING!

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COLLABORATIVE CASE STUDY/TIME PERMITTING/AUDIENCE PREFERENCE

PCP NP providing home care visit encounters the following:

- 88-year-old man with CHF, dementia, urinary retention, lives at home with his 50-year-old daughter who is his full-time caretaker.
- Patient only sleeps 90 minutes at a time, keeps trying to get out of bed. Sometimes states he had to urinate, sometimes just tried to get out of bed and would get agitated when putting his leg when trying to get out of bed and would call for help.
- Caregiver becoming frustrated because she is unable to get a good night's rest.
- Daughter does not want invasive or intensive intervention at this point.

COLLABORATION CONTINUED/TIME PERMITTING

- Medical issues ruled out: UTI, urinary retention (via traveling ultrasound), electrolyte imbalances.
- Once medical issues were ruled out, collaboration with psychiatry was implemented.
- Various (and every) drug class was tried to decrease the patient's agitation: anticholinergics, benzodiazepines, anti-psychotics, with no effect

WHAT WAS THE RESULT?

- Discuss