# Common Behavioral and Physical Health Co-Morbidities

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Psychiatry & Behavioral Sciences

DR. ROBERT BREE COLLABORATIVE

# Welcome

**Victoria Evans, LICSW, MHP, CDP**
WA State Director of Behavioral Health, Molina Healthcare

# Introductions

- **Mark Duncan, MD**

  Assistant Professor, UW Psychiatry & Behavioral Science, Provider Trainer, UW AIMS Center

- **Charissa Fotinos, MD, MSc**

  HCA Deputy Chief Medical Officer, Health Care Authority

- **Sasha Waring, MD**

  Sr. Behavioral Health Medical Director, Molina Healthcare

  Child, Adolescent and Adult Psychiatrist

- **Sara Barker, MPH**

  Assistant Director Implementation, UW AIMS Center

# Objectives

- Identify common behavioral health and physical health co-morbidities through the lens of various practices where members may seek care.
- Identify key elements of behavioral and physical health care assessments.
- Address considerations for an integrated care plan.
- Address strategies across service settings.
- Emerging roles for whole person care.
- Q&A (15 min)

# Co-occurring mental health, physical health, and substance use problems

**Mark Duncan, MD**
Addiction Psychiatrist, Family Medicine
Co-director Psychiatry and Addiction Case Conference,
University of Washington

# Co-occurring mental health, physical health, and substance use problems

- Goals
  - Highlight the interaction between substance use, mental, and physical health
  - Describe a hierarchy of competing priorities
  - Identify some practical steps in treating patients with mental, physical, and substance problems

# Part 1: 29yo F to M transgender patient presents for evaluation of his Opioid Use

- PMH
  - history of congenital adrenal hyperplasia, and regular ED visits for adrenal crisis, triggered by a cyclic vomiting syndrome. On hydrocortisone.

- Substance use history
  - Opioids: Opioid use disorder started 6 years ago with prescription opioids which he started taking due to pain. Eventually transitioned to methadone which he was getting from a pain doctor. After his doctor closed his practice and left the country he went through withdrawal and stopped using. Returned to daily heroin use due to chronic pain after 3 years sober without treatment about 3 months ago.
  - Cannabis daily, but would like to reduce his use.

- Psych history
  - Depression and anxiety
  - GAD7 15, PHQ9 10
  - Currently taking Sertraline 150mg a day and tolerating it well

# Next Steps: 29yo F to M transgender patient presents for evaluation of his OUD

- Questions to Consider
  - What are his diagnoses?
    - Opioid Use disorder-severe
    - Depression and anxiety
    - Cyclic Vomiting syndrome/Adrenal crisis
  - What are some potential next steps and what do I need to consider
    - OUD→starting medications for his OUD.
    - Assess how his depression and anxiety may handle the transition from heroin to medications for OUD
    - What about his cyclic vomiting and adrenal crisis?

Plan: start home induction on Buprenorphine-Naloxone

# Part 2: 29yo F to M transgender patient presents for evaluation of his OUD

- OUD-started induction on Buprenorphine-Naloxone
  - Stopped both the Cannabis and Heroin on day 1 of induction. 6 hours later he presented to the ED after having a vomiting episode and feeling like he was entering an adrenal crisis. Stabilized in the ED and started taking Buprenorphine-Naloxone consistently. + mild cravings. No withdrawal symptoms. He is taking 12mg of Buprenorphine. No illicit opioids.
  - Psych: anxiety was high the week of induction, but started to improve after he got on the Buprenorphine-Naloxone. No SI. PHQ9: 13, GAD7: 10
  - Plan:
    - increase Buprenorphine-Naloxone to 16mg-4mg for persistent cravings.
    - Continue Sertraline 150mg qday
    - Reconnect with his past therapist who he saw at his local community mental health center
    - Recommend he reduce or (even better) stay off the Cannabis

# Part 3: 29yo F to M transgender with OUD on Bup-Nal with acute pain problem

- About 2 months later the patient calls your clinic because he is at home after accidentally getting the tips of his 3rd and 4th digit caught in the timing belt of his car, resulting in the amputation of those distal phalanges.  He is post-op and back at home later that day, and his nerve block is wearing off. He is asking for some help for pain relief.
  - Options:
    - increase Buprenorphine-Naloxone to 16mg-4mg to 24mg-6mg or have him split his existing dose
    - Use full agonists on top of current Buprenorphine-Naloxone for 2 days
    - Add NSAIDs and Acetaminophine for pain relief

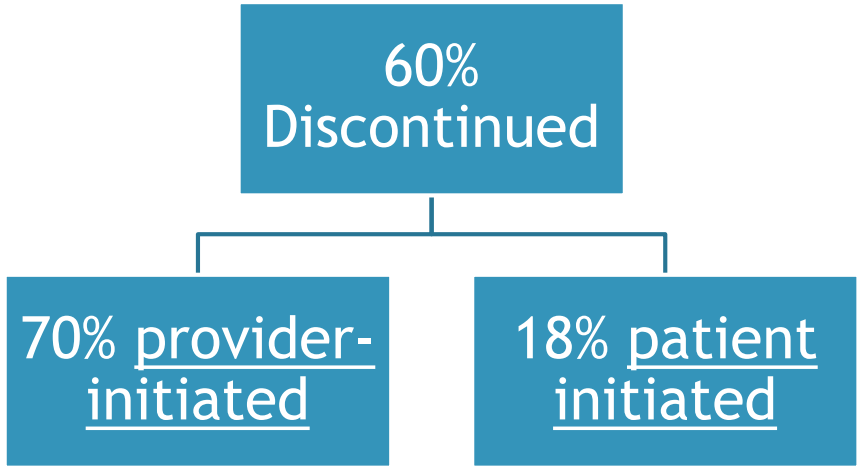
Plan: start Naproxen 500mg bid prn for pain

# The balance between physical, mental, and substance use

# **Question**: what might happen if patients on chronic opioid therapy have their opioids discontinued?

- Setting: Harborview Adult Primary Care Clinic 2010-2015
- N=572 on opioids, Mean age=55yo
- 2010 Morphine Equivalent Dose Range: 120mg-359mg

- Opioid Discontinuation
  - N=344






James J et al, 2019

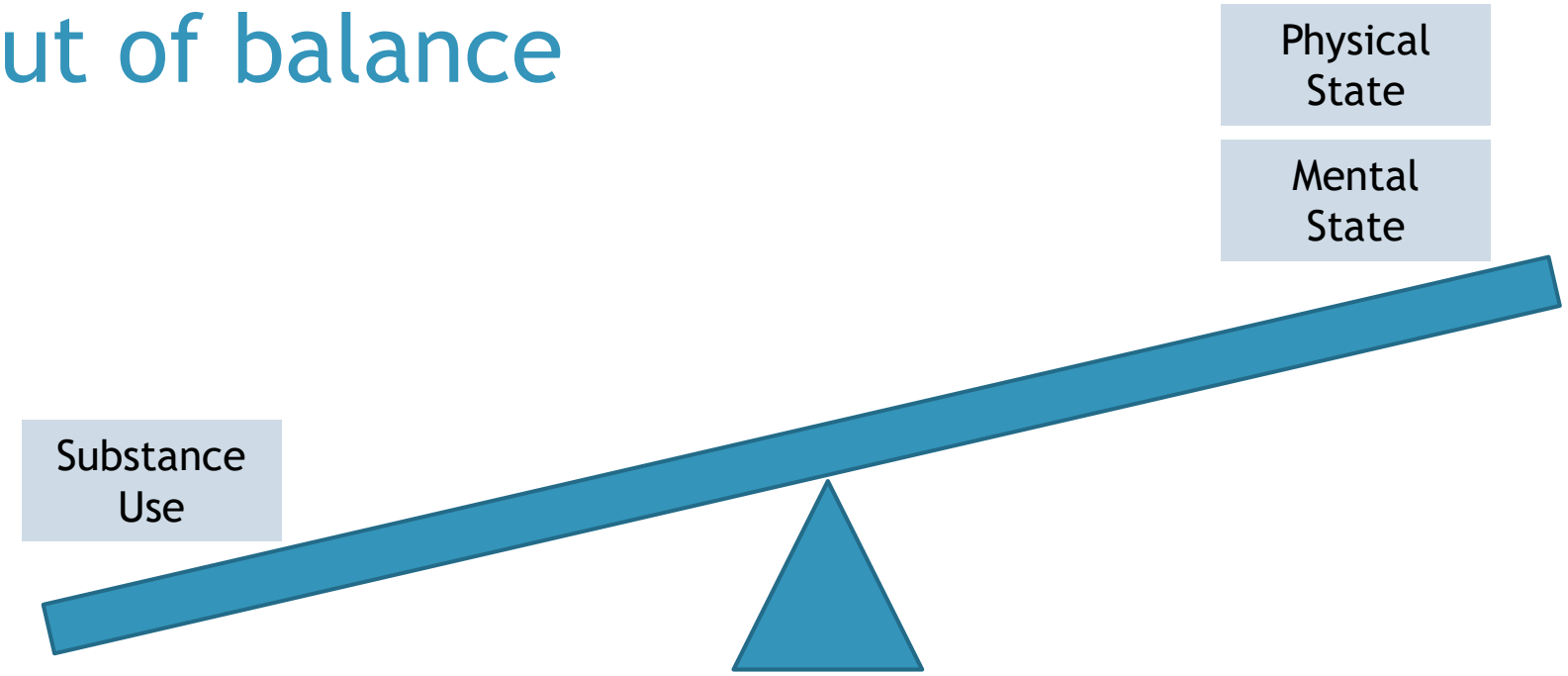
# **Question**: what might happen if patients on chronic opioid therapy have their opioids discontinued?

- Opioids ***Dis***continuation
- Opioids Continued


- **HR: 2.94 (adjusted for age and race)
  - All deaths in discontinued group had at least 1 provider-initiated reason

James J et al, 2019

# Out of balance

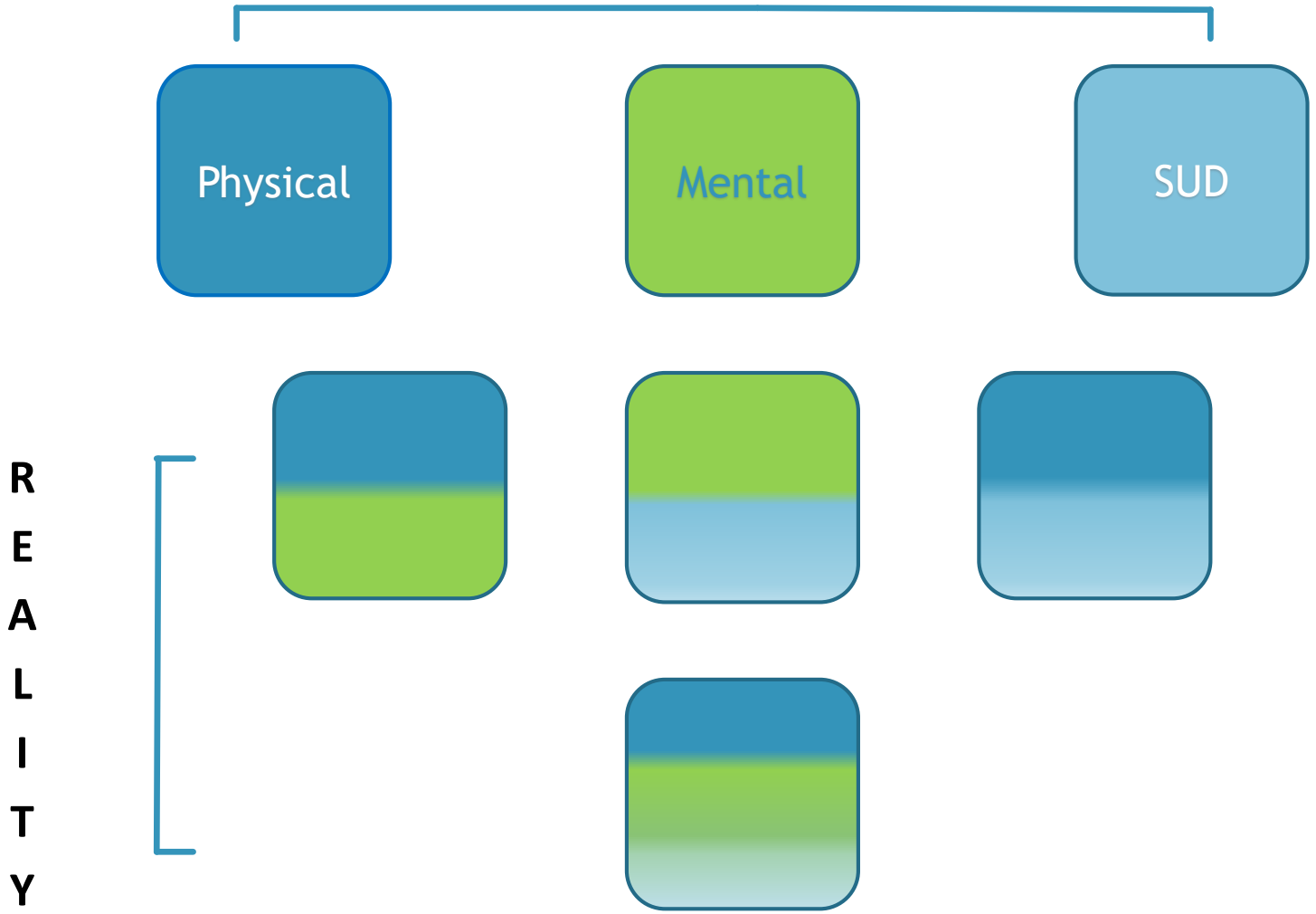



- Takeaways
  - There are risks associated with disturbing the balance of substance use, physical state, and mental state
  - Assess for substance use disorders if stopping a controlled substance and treat it
  - Assess mental health safety issues→PHQ9 #9 is a great suicide screening question
  - Educate patients on loss of use illicit substances, tolerance, OD risk
  - Be prepared for a worsening of mental health symptoms and consider support options→therapy, starting a medication
  - Outside case consultation can be helpful for the patient and yourself

# Co-morbidities in Primary Care

**Charissa Fotinos, MD, MSc**
HCA Deputy Chief Medical Officer
Health Care Authority

# DISCIPLINES



# Multiple Influences


Source: Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal, 29*(4), 311–314.

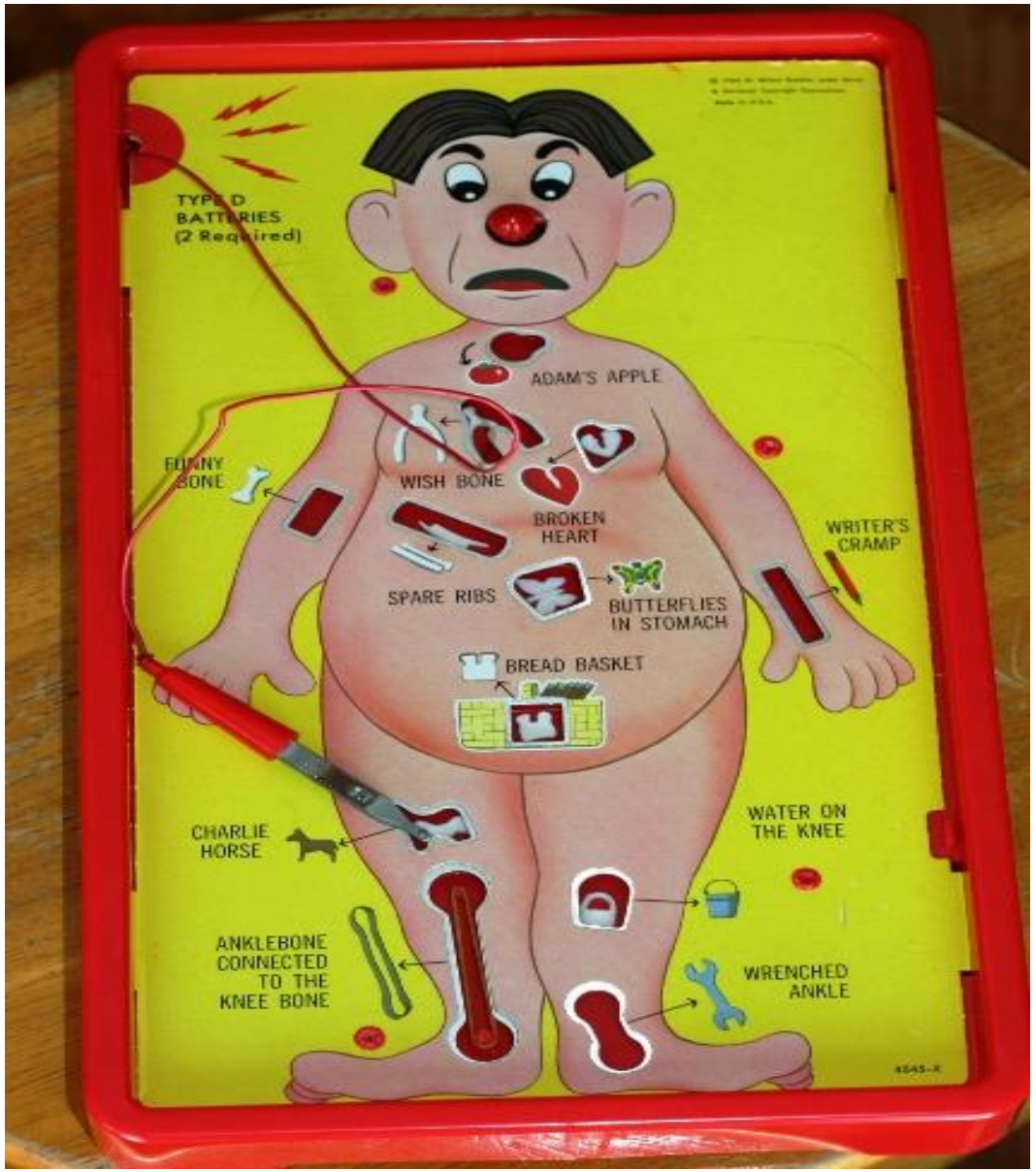
https://store.samhsa.gov/system/files/sma16-4953.pdf

# Primary Care Examples

- 43 yo woman. Works in the financial sector in a high stress job. Problems include above average BMI and HTN that despite 2 medications remains elevated. Owns her own home and enjoys yardwork on the weekends.
- 65 yo women with long standing schizophrenia and COPD. 40+ pack year cigarette history, no alcohol use for years. Would use an inhaler but refused all other examinations and medications.
- 70 yo man with CAD and CHF. He also suffered from severe depression seemingly refractive to medication.
- 26 yo young man. HIV+. Intermittently on medications for HIV.

# Observations

- In the absence of an acute illness or injury, people rarely have one condition
- Sometimes when folks don't respond to usual treatment or aren't amenable to your recommendations, more history is needed.
  - Context is critical and patience is key.
- Working with patients to address what is most important to them, in the absence of imminent risk, helps to build trust
- Not asking questions because you are not sure what to do or 'there aren't any resources anyway' can harm patients
- Co-existing condition management requires someone assuming the 'lead provider' role and ongoing communication


TYPE D
BATTERIES
(2 Required)
ADAM'S APPLE
FUNNY
BONE
WISH BONE
BROKEN
HEART
WRITER'S
CRAMP
SPARE RIBS
BUTTERFLIES
IN STOMACH
BREAD BASKET
CHARLIE
HORSE
WATER ON
THE KNEE
ANKLEBONE
CONNECTED
TO THE
KNEE BONE
WRENCHED
ANKLE

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# Questions?

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# Co-existing conditions in youth and adults with psychiatric illness

**Sasha Waring, MD**
Sr. Behavioral Health Medical Director, Molina Healthcare
Child, Adolescent and Adult Psychiatrist

# Psychiatric co-morbidities: ADHD

- 2/3 have 1+ coexisting condition
- 40% have ODD
- Conduct Disorder common (27% of kids, 45% of teens)
- Depression: 14% of kids, 47% of adults (kids w/o ADHD: 1%)
- Anxiety Disorders: 30-50%
- ASD: ~25% have at some traits; 50% of individuals with autism have ADHD
- Tourette: <10%, though >60% of those with TS have ADHD

# Other health co-morbidities: ADHD

- Sleep disorders
- Substance use disorders
- Learning disorders
- Peer problems
- Injuries

# Psychiatric co-morbidities: Depression

- Substance Use Disorders (58%!)
  - Alcohol, Nicotine most common
  - OUD
- Anxiety disorders: 37%
  - GAD
- Personality disorders: 32%
  - Borderline PD

# Physical health co-morbidities: Depression

- Diabetes
  - Bidirectional risks
  - Collaborative, synchronous treatment improved both conditions
- CVD
  - Depression and Anxiety predict CVD development and worsen prognosis
  - Not yet clear that screen/treat of Depression/Anxiety improves CVD
- Respiratory Diseases- COPD and asthma
  - Relationship bidirectional, complex, poorly understood

# Physical health co-morbidities: Schizophrenia and Bipolar Disorder

- Diabetes
- CVD: #1 cause of death
- Respiratory Diseases:
  - high smoking rates linked to higher rates and worse progression of COPD/Asthma

# Cancer and Psychiatric Illness

- Depression and anxiety common in people with cancer
- Cancer more common in people with psychosis- likely related to health risk behaviors, less access to health care
- Individuals with SMI more likely to present with more advanced stage cancers, poorer survival rates

# Tips for behavioral health clinicians

- Work to reduce stigma/discrimination against those with severe mental illness
- Encourage screening, initial and ongoing treatment for co-existing physical health conditions (DM, CVD, etc)
- Collaborate with PCPs and other health professionals in care of those with co-existing conditions
  - May enhance trust in other providers
  - Share information about beliefs toward treatment, adherence strategies

# References


- Hasin DS, Sarvet AL, Meyers JL, et al. Epidemiology of adult DSM-5 major depressive disorder and its specifiers in the United States. *JAMA Psychiatry*. 2018 February 14.
- Druss et al. Mental disorders and medical comorbidity. RWJF: Synthesis Project.
- Cohen et al. Addressing comorbidity between mental disorders and major noncommunicable diseases. Background technical report of the WHO European Mental Health Action Plan 2013-2020.

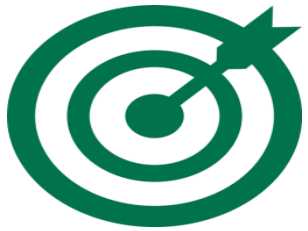
# Whole Person Care Strategies Across Settings

**Sara Barker**
Assistant Director for Implementation
University of Washington AIMS Center

# Principles for Evidence-Based Integration

**Team-Based and Person-Centered**
Primary care and behavioral health providers collaborate effectively, using shared care plans.

**Population-Based and Data-Driven**
A defined group of patients or clients is tracked in a registry so that no one "falls through the cracks."



**Measurement-Based Treatment to Target**
Treatment goals clearly defined and tracked for every patient. Treatments actively changed until clinical goals are achieved.



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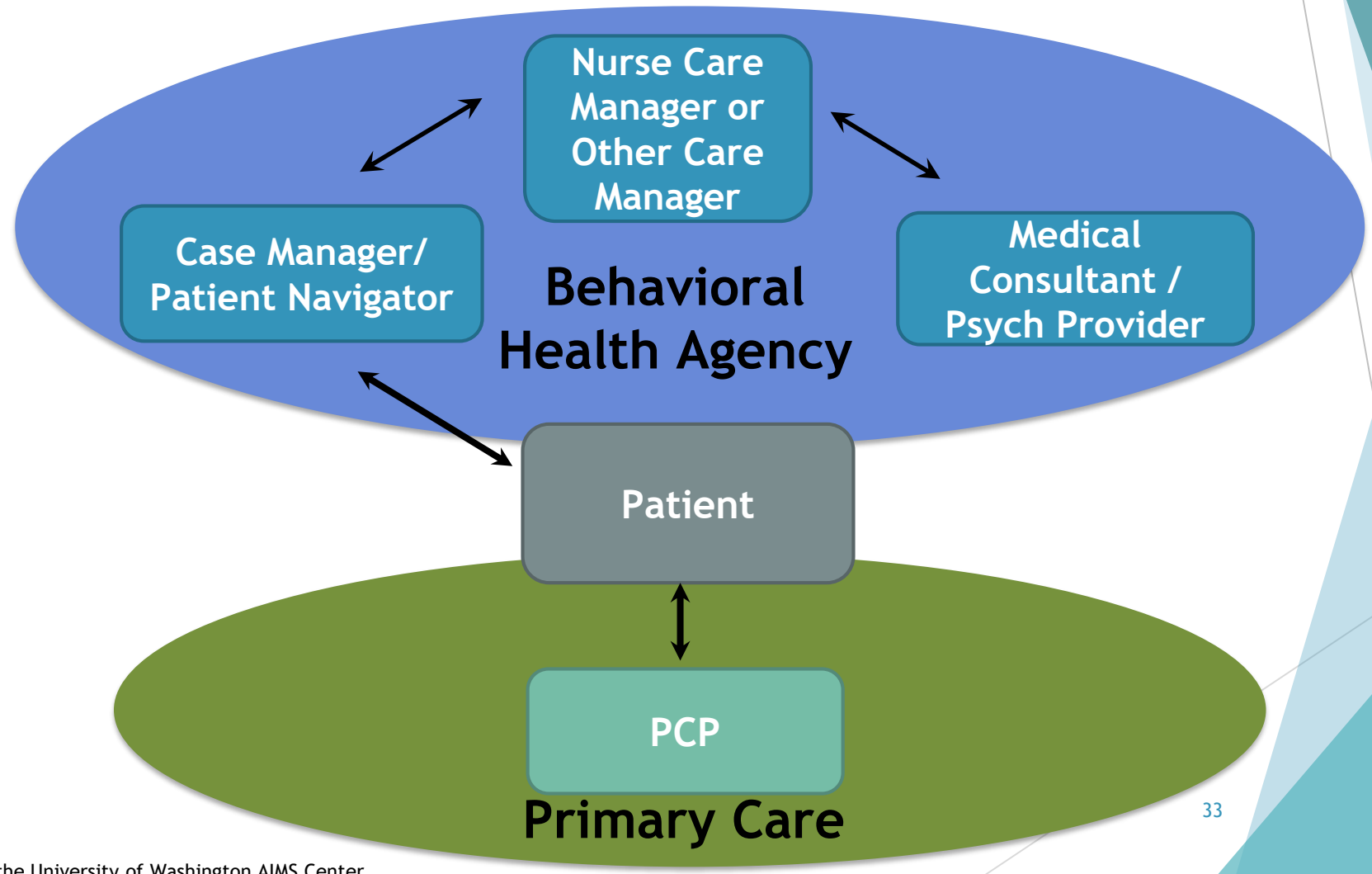
# Team Strategies Across Settings



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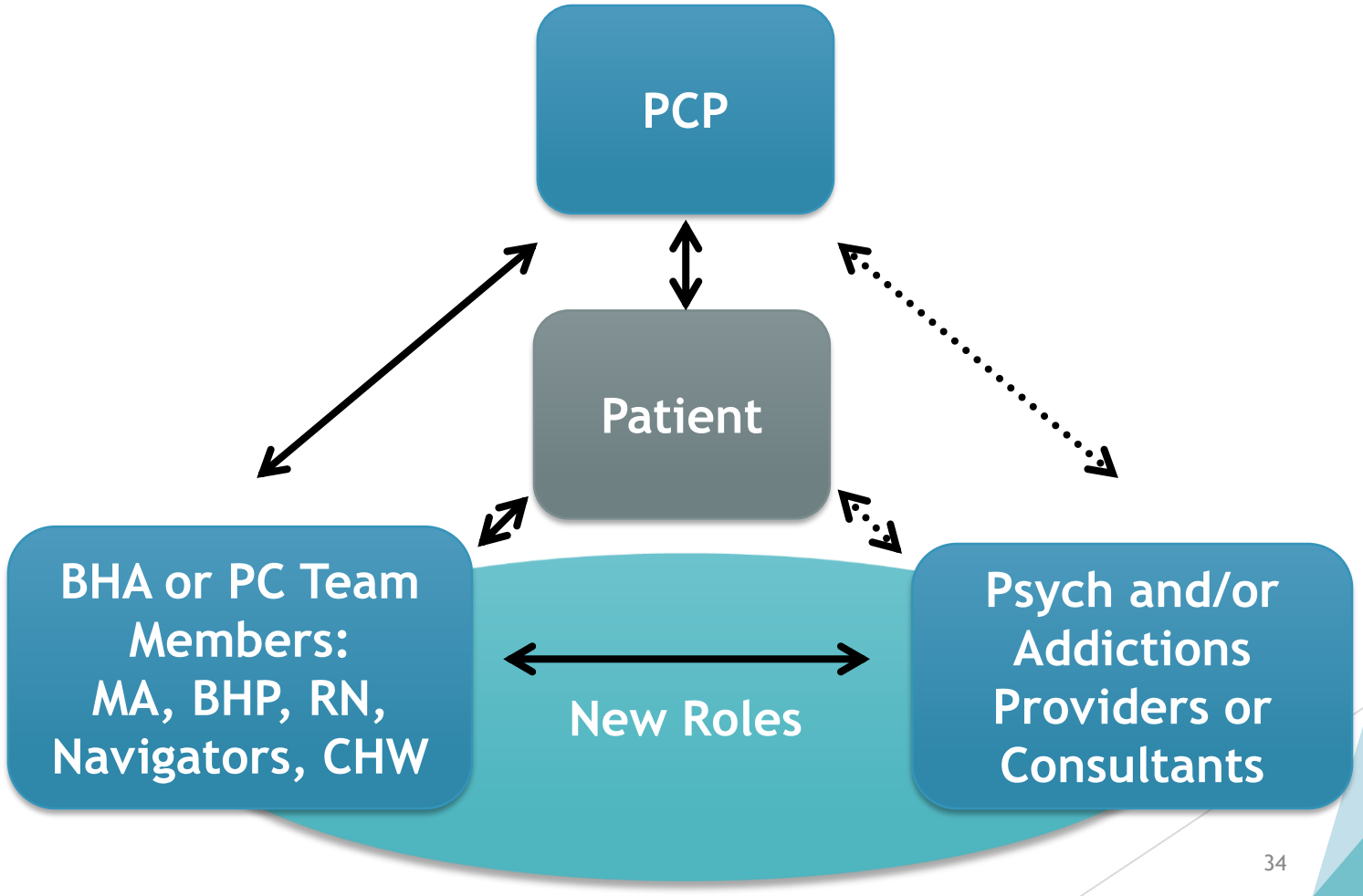
# Team Strategies Across Settings



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# Emerging Roles for Whole Person Care

- Patient Navigator/Care Coordinator/Case Manager
  - Linkages across settings and helps the patient navigate different treatment settings
  - Patient engagement and relationship building
  - Support health behavior change activities, including motivational interviewing and behavioral activation
- Nurse or Behavioral Health Care Manager
  - Caseload/population-based care approach, oversight of data
  - Brief interventions: medication management, chronic condition management, motivational interviewing, behavioral activation
  - Evaluate patient progress, support retention, manage relapses
- Psychiatric Consultant/Addiction Medicine/Medical Consultant
  - Expertise around medications
  - Treatment recommendations
  - Development of clinical protocols/pathways

# Example 1: Behavioral Health Agency and Primary Care Clinic Partnership

- Provided by the Behavioral Health Agency:
  - Psychiatric provider serves as a consultant to the primary care clinic's patients with depression and anxiety
  - Behavioral health specialist co-located at the primary care clinic
  - Psychiatric aide and provider identify behavioral health patients on psychotropic medications with diabetes and cardiovascular disease, track patients on a registry
- Provided by the Primary Care Clinic:
  - Primary care provider sees patients for their physical health needs three days a week at the behavioral health agency
    - Also provides MOUD at the clinic
  - Nurse care manager manages patients on suboxone and assists with home inductions

# Example 2: Rural Behavioral Health Agency and Collaboration with Primary Care

- Provided by the Behavioral Health Agency:
  - Nurse care manager manages clients with high blood pressure and also assists suboxone treatment for clients part of MOUD, oversees registry of clients so no one falls through the cracks
  - Case manager helps lead CDSM classes for clients and works with nurse to connect clients with a primary care provider

- Provided by the Primary Care Clinic:
  - Shared access to electronic health record with the nurse care manager from the behavioral health agency
  - Primary care nurse collaborates with the case manager and nurse care manager at the behavioral health agency to develop wellness classes and groups
  - Primary care provider assists in the development of protocols around hypertension and diabetes management for the behavioral health agency

# What AIMS Center is Learning from ACH Work

- Development of stepped care approaches and partnerships for whole-person care are essential
- Organizational readiness is critical and planning takes time
- Defining a few data points to collect are enough to do meaningful measurement-based care
- New and emerging team roles in whole-person care require support to get launched
- Financing and sustainment still a ***big ?*** for whole-person care

# WA Provider Resources

## *Expert Support for Diagnostic Clarification, Medication Adjustment or Treatment Planning*

- **UW Psychiatry Consultation Line (PCL)**
  - Providers caring for 18+ patients with mental health and/or substance use disorders
  - Call 877-927-7924 (877-WA-PSYCH)
  - https://sharepoint.washington.edu/uwpsychiatry/ClinicalServices/ConsultationandTelepsychiatry/Pages/pcl.aspx
- **UW Perinatal Psychiatry Consult Line for Providers (PAL for Moms)**
  - Providers caring for pregnant or postpartum patients
  - Call 877-725-4666 (PAL4MOM)
  - https://www.mcmh.uw.edu/ppcl
- **WA Partnership Access Line (PAL)**
  - Providers caring for children or adolescent patients
  - Call 866-599-7257
  - https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/wa-pal/

# WA Provider Resources

## *Case Consultation & Skill Building*

- **UW Psychiatry and Addictions Case Conference (UW PACC)**
  - Providers who care for patients with mental and behavioral health conditions
  - Thursdays 12-1:30pm, Ongoing
  - http://ictp.uw.edu/programs/uw-pacc

UW PACC
Psychiatry and Addictions Case Conference
UW Medicine | Psychiatry and Behavioral Sciences

- **Community-Based Integrated Care Fellowship**
  - Year-long fellowship for psychiatric providers seeking additional training to deliver integrated care
  - March 2020 – February 2021 Applications: Closed
  - https://ictp.uw.edu/programs/community-based-integrated-care-fellowship

# Questions and Answers

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