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Collaborative care for a patient with bipolar disorder in primary care: a case example

Joseph M. Cerimele, MD, MPH¹, Anna Ratzliff, MD, PhD¹, and Jennifer M. Sexton, MD¹

¹University of Washington School of Medicine Dept. of Psychiatry and Behavioral Sciences, Seattle WA

Abstract

Objective—To describe the process of care and treatment outcomes of a 36 year-old man with bipolar disorder treated using a collaborative care model in primary care.

Methods—We reviewed and summarized relevant clinical data describing the patient's care including the medical record, consultant's reports, and discussions with treating clinicians. A meeting was held with experienced consulting psychiatrists to discuss the case.

Results—Several barriers to delivery of high quality care existed including initial loss to follow-up, few social supports, and lack of follow-through at the community mental health center existed, along with presence of factors that negatively influence bipolar disorder outcomes including initial unopposed antidepressant use at baseline, concurrent alcohol use, and co-occurring anxiety symptoms. Despite these barriers, the collaborative care team was able to engage the patient in care and achieve the patient's and team's treatment goals.

Conclusion—Delivery of primary care based collaborative care was associated with reduction of bipolar disorder symptoms and improved functioning in a patient with bipolar disorder.

Keywords

Bipolar disorder; primary care; collaborative care

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Corresponding author: Joseph M. Cerimele MD, MPH, Acting Assistant Professor, University of Washington School of Medicine, Department of Psychiatry and Behavioral Sciences, 1959 NE Pacific St., Box 356560, Seattle, WA 98195-6560, Phone : 206-221-4928, Fax : 206-543-9520, cerimele@uw.edu.

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Introduction

Collaborative care models are increasingly used in medical settings to treat populations of patients with common psychiatric illnesses such as major depression [1]. A substantial evidence base demonstrates the effectiveness of collaborative care in primary care settings, though most studies have focused on treating patients with depression or anxiety disorders [2]. The existing collaborative care trials that have included patients with bipolar disorder have been conducted in mental health settings [2]. Here, we present the case of a patient with bipolar disorder treated with collaborative care in a community primary care clinic.

Case Report

A 36 y/o man, Mr. R., presented to a primary care clinic reporting a two year history of depressed mood, anhedonia, and irritability. Mr. R's main concern was having a "short fuse" resulting in many interpersonal arguments. Other symptoms included restlessness, anxious preoccupations, low energy, low appetite, and guilt. Suicidal ideation and psychosis were absent. He intermittently drank alcohol with some binge drinking. His medical history included only mild asthma.

The patient was diagnosed with major depression and received treatment with bupropion 150mg daily. Over the next seven months, the patient continued experiencing the above symptoms and described worsening irritability. He continued drinking alcohol several times per week, and during one binge was involved in an argument with his wife resulting in Mr. R. being arrested. Mr. R's primary care physician (PCP) modified the patient's treatment using a combination of brief in-office counseling regarding alcohol use, and medications including combinations of bupropion 150mg daily, sertraline up to 150mg daily, trazodone 50mg at bedtime, and lorazepam 2 to 3 mg per day. The patient and PCP noted no appreciable symptom reduction from these treatments.

Eight months after initial presentation, the PCP recommended the patient receive treatment using collaborative care which the clinic had used for approximately three years [1]. That day, the patient met with the clinical care manager (a master's level mental health clinician) in the primary care clinic to initiate collaborative care. The care manager spent one hour with the patient learning about his history and experience with symptoms. Mr. R. was raised by his single mother (who had bipolar disorder) and early in adulthood moved to live with his father, who had an alcohol use problem. Mr. R worked over the prior decade as a construction engineer and was later self-employed as a carpenter. The patient had not previously received psychiatric care. He smoked cannabis daily in the past but had not used it for three years. The patient described experiencing depressive symptoms intermittently since childhood.

With the care manager, the patient completed several standardized symptom measures including the Patient Health Questionnaire 9 (PHQ-9) (scoring 13 out of 27 indicating moderate depressive symptoms) [3], the Generalized Anxiety Disorder 7 (GAD-7) (scoring 12 out of 21 indicating moderate anxiety symptoms) [4], the Global Appraisal of Individual Needs Short Screener (scoring 3 out of 5 indicating a high probability of a substance use

problem) [5], and the Mood Disorder Questionnaire (MDQ) (scoring 12 out of 14, plus the symptoms occurring during the same time period and were a moderate problem, indicating a positive screen for bipolar disorder) [6].

To address the positive MDQ screen, the care manager asked about duration and frequency of mood episodes and concurrent substance use. The patient reported earlier the same year, prior to receiving antidepressant treatment and during a period of abstinence from substances, he experienced several weeks of elevated mood, increased activity and energy, racing thoughts and impulsive behavior. During that time, he married a woman after knowing her for three weeks, and soon after the wedding, spent over \$20,000 and flew with her to Europe. Several weeks later, the elevated mood, increased activity and associated symptoms subsided without treatment, and depressed mood, anhedonia and irritability recurred. He lost his job due to a prolonged absence from work, and withdrew socially.

The care manager described collaborative care to the patient, including the clinicians' roles of closely following his symptoms and treatment targets, and the patient's role in treatment such as practicing self-care skills and completing standardized symptom assessments. She entered the patient's clinical information into a registry used by clinicians in collaborative care to track patients' care. This includes measures such as the PHQ-9, clinical interventions such as current and prior medications, and treatment outcomes such as resolution of mood episodes. Several days later, the care manager spoke with the consulting psychiatrist for their weekly meeting to review patients. The care manager and psychiatrist accessed the patient registry and focused their discussion on patients who were either new to collaborative care or continuing to demonstrate non-response to treatments.

The psychiatrist's impression was Mr. R. likely had bipolar disorder, and recommended safely discontinuing bupropion, sertraline and lorazepam, and initiating lamotrigine 25mg daily (with a goal dose of 200mg daily). Additionally, the psychiatrist advised the care manager to gather information on prior mood episodes as well as prior and current substance use, and to offer counseling supporting sobriety.

The care manager communicated the psychiatrist's recommendations to the patient's PCP. One week later, the PCP, care manager, and patient discussed the potential diagnosis of bipolar disorder and psychiatrist's treatment recommendations. Together they developed measurable treatment goals such as decreasing symptoms to a PHQ-9 score less than 10, abstinence from alcohol, strengthening of friendships, and reducing irritable outbursts from daily to less than two per week.

Over the next two months, Mr. R. experienced ongoing irritability and depressive symptoms. However, he continued attending appointments with the PCP and the care manager at the primary care clinic due to the care manager's repeated outreach by phone. The care manager updated the patient registry with new clinical information, and discussed the patient's treatment progress with the psychiatrist. Treatment with risperidone 0.5mg daily followed by quetiapine 150mg daily was initiated by the PCP and then discontinued due to the patient experiencing increased restlessness and sedation, respectively. Lithium

was then initiated and titrated to 600mg per day, though the patient only partially adhered to the prescribed amount.

In the context of stressors including separating from his wife and moving, Mr. R. resumed alcohol use of several drinks per day and experienced worsening irritability and depressive symptoms (PHQ-9 score of 18). Because of the worsening clinical status despite multiple interventions in primary care, the patient and collaborative care team thought Mr. R. would benefit from direct psychiatric care in a community mental health clinic (CMHC). The patient attended one appointment at the mental health clinic, but did not return for follow-up care.

Mr. R remained on the collaborative care registry, even though he was referred to a CMHC and had subsequently missed several primary care appointments. The care manager continued reaching out to Mr. R. by phone to encourage his return to treatment, and successfully re-engaged him in care by shifting the treatment focus to sobriety which was now the patient's primary goal. Mr. R. returned to the primary care clinic. He began attending Alcoholics Anonymous meetings. The patient also attended Self-Management for Addiction (SMART) Recovery (a recovery support group focused on development of skills supporting abstinence) meetings to learn to manage urges to use alcohol and to enhance problem solving skills. Treatment with lamotrigine 25mg daily (increased gradually to 200mg per day) and quetiapine 100mg daily was resumed and tolerated. Over the next two months, Mr. R. attended appointments with the care manager and PCP, and had achieved three of his four main treatment goals including abstinence from alcohol, a significant reduction in depressive symptoms (PHQ-9 score of 7), and engagement with friends. Although he did not decrease irritable outbursts to twice per week, the frequency of outbursts decreased from nearly daily to approximately half of days.

Discussion

Patients with complex psychiatric and substance use treatment needs, such as Mr. R, make up approximately 20–30% of individuals receiving collaborative care in some primary care safety net clinics [7, 8]. Prior to initiating collaborative care, Mr. R remained symptomatic and had associated psychosocial impairment despite usual primary care treatment. The strengths of collaborative care in Mr. R's treatment included proactive follow-up through use of a registry, questionnaires and multiple clinician visits resulting in accurate diagnosis of bipolar disorder, rapid adjustment of treatments based on measureable outcomes or side effects, provision of psychiatrist-informed care in a general medical setting, and accountability for his clinical outcome despite the patient intermittently missing appointments [1, 9].

Collaborative care is a population-based treatment involving a care manager facilitating mental health treatment in primary care in collaboration with the PCP, and a consulting psychiatrist who regularly reviews cases with the care manager, offering assessment and treatment recommendations [1, 9, 10]. Use of an electronic registry and standardized measures such as the PHQ-9 by the primary care staff and clinical care manager promote case identification, follow-up, and treatment to target using stepped-care strategies informed

by the standardized measures and evidence-based treatment guidelines. Registry use also encourages proactive follow-up by the care manager of patients not engaging in care.

Approximately 80 clinical trials demonstrate that collaborative care is significantly more effective than usual care in treating patients with depression and anxiety disorders in primary care [9, 10]. However, the clinical practice of collaborative care has revealed that, like Mr. R., a significant minority of patients referred for collaborative care treatment in primary care have bipolar disorder. In our experience in Washington State, bipolar disorder occurs in approximately 15% of primary care patients in the Mental Health Integration Program (MHIP), a large state-wide program that has integrated collaborative care treatment programs into over 130 clinics [8, 11].

We discussed this patient's care at a conference with a group of experienced collaborative care psychiatrists. The consulting psychiatrists who attended the conference consulted to primary care clinics involved in MHIP, and included many of the consulting psychiatrists from a study examining the views of consulting psychiatrists on treating patients with bipolar disorder in primary care (12). A major challenge for psychiatrists in collaborative care is balancing the uncertainty of indirectly caring for a patient, with the need to decisively assist primary care teams with managing a patient population with complex medical and psychiatric comorbidity. Psychiatrists' lack of direct access to the patient and the medical record results in relying on clinical information obtained and presented by the care manager. Regular meetings with the care manager to review patients treated in collaborative care allows consulting psychiatrists to provide education on key clinical points such as assessing for history of hypomania or mania, and guidance on evaluating subtle parts of a patient's mental status such as activity level or presence of racing thoughts, so that those clinical points can be assessed by either the care manager or the PCP.

Additionally, primary care clinics are hectic, and patients may stop treatment without notice. Therefore, initiating treatments in primary care for serious psychiatric illnesses requires a careful approach, and consulting psychiatrists in collaborative care may wish to directly see complex patients like Mr. R. either in person or using telehealth technology to confirm diagnoses and treatment plans. The majority of consulting psychiatrists working in MHIP, including the consulting psychiatrist described in this case, are geographically separated from the clinics to which they consult, making in-person assessment of patients less feasible. Referral to a community mental health clinic may also be appropriate for some patients with bipolar disorder. However, several barriers including long waiting lists for initial appointments at some mental health clinics, strict entry criteria into some community mental health centers such as needing to have had a recent psychiatric hospitalization, patient lack of insurance, few available psychiatrists in mental health clinics, and some patients' preference to receive care in primary care can contribute to lack of follow-through for patients referred to mental health clinics.

Approximately half of consulting psychiatrists in our conference revealed they would have recommended bipolar disorder specific treatment for Mr. R. after one consultation with the care manager as the psychiatrist in the case did noting the risks associated with inaction, such as worsening disease course and potential development of greater treatment resistance,

and the risk of the patient not returning for treatment due to increasing symptom burden. The remaining half of consulting psychiatrists would have first gathered additional historical information to confirm the history of mania versus the diagnosis of substance use, and weigh the risks of bipolar disorder treatments in an individual who may not have bipolar disorder. Some consulting psychiatrists noted that results from the Composite International Diagnostic Interview (CIDI) (a brief, structured assessment for bipolar disorder commonly used in MHIP, but not administered in this case, available to care managers in the web-based registry) would have increased their confidence in preliminarily diagnosing bipolar disorder [13].

A major unifying discussion point from our case conference was development of measureable treatment targets for this patient as early as the first consultation with the care manager. Collaborative care treatment emphasizes treat to target interventions such that patients who are not improving receive additional interventions (stepped-care). Partly due to clinicians utilizing stepped care interventions, clinical trials have demonstrated that compared to usual care, a greater proportion of patients receiving collaborative care achieve a clinically significant reduction in depression symptoms [9, 10, 11].

The psychiatrists in our case conference described that over time, primary care clinicians working in clinics with established collaborative care tended to initiate several steps of treatment before referring patients for collaborative care treatment, often leading to referral of complex patients such as Mr. R. Based on our experience, psychiatrists working in collaborative care should expect to treat patients with various psychiatric illnesses such as bipolar disorder, not exclusively patients with major depression or anxiety disorders.

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