PARTNERSHIP

PROMOTING SAFETY & SUCCESS in PSYCHOPHARMACOLOGICAL TREATMENT

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Doctor & Patient Roles
History Always Tells a Story

• Active/Passive role = Traditional Paradigm
• Doctor has special knowledge of complicated biology
• Doctor “controls” patient’s free choice, directs patient back to health
• Inequality of Knowledge = Inequality of Power
• Medical Ethics: duty bound to help, patient welfare #1
• Duty to take care of patient even if patient couldn’t pay (not sustainable)
• Doctor-Patient relationship unconstrained by market or governmental forces

Doctor & Patient Roles
History Always Tells a Story

• Patient’s lack of “negative freedom” not an issue

• Advent of insurance, MCD, MCR did not change power paradigm

• 3rd parties pay, exercise little control, docs still run the show

• “American medicine had become a thoroughly peculiar set of political and economic institutions.”(Brennan, p. 46)
Doctor & Patient Roles
History Always Tells a Story

• Patients lacked exclusive knowledge & difficulty accessing info (no internet or Facebook)

• Capacity to participate can be negatively affected r/t illness state (this has not changed)

• Enormous trust in doctor & medical establishment

• Assumed he (usually a he) acting in patient’s best interest (a form of paternalism)

• Expert knows best: doctor decides the treatment (What medical school did you go to?)

Doctor & Patient Roles
History Always Tells a Story

• This is getting expensive (Obama didn’t start the fire)
• 1973 Our Bodies Ourselves published
• Consumer protections becoming standard
• 1980’s DRG’s end up not controlling cost
• Organized medicine & hospital’s power “weakened”
• 1990’s “It’s All About Me” in full swing
• We all want Prozac
• Concerns about “cosmetic” psychiatry
21st Century Paradigm

• We survive Y2K!! Information explosion continues
• Health care money pot rapidly disappearing
• What’s best for pt: Mutual vs. Exclusive Process
• Questioning what best really means
• Freedom to choose has to be balanced against mutual duties

• Impetus for more effective & efficient care & practice models (“evidence based” & “best practices”) growing
• Just ‘cause you can doesn’t mean it’s good or necessary

21st Century Paradigm

• AMA on board with patient right to determine treatment by making informed choice

• BUT, power & control battles not over, especially economically

• “Physicians must give up control, especially in economic decision making, and become patient advocates. This may be asking too much—I am unsure that it can occur.”

(Brennan, p. 238)
Health Behavior Terminology
Old Paradigm

COMPLIANT
• Fulfilling the caregiver’s course of treatment
• Active caregiver/Passive patient
• Power & control in caregiver

NON-COMPLIANT
• Patient didn’t do what he or she was told
• Assumes patient was irrational or willfully ignoring the caregiver’s plan

Health Behavior Terminology
New Paradigm

MOTIVATION
• Movement in the direction of reaching a goal
• Involves an *interplay* of:
  - Personal attributes
  - Environmental influences
  - Relationship systems

ADHERENCE/CONCORDANCE
• Commitment or attachment to a *collaboratively* developed regimen; a decision making alliance

(Foster, et al, 2011)
ALLIANCE

• **Partnership** between two or more parties that pursue a set of agreed upon goals

(Foster, et al, 2011)

Implications of Inadequate Partnership

Patient

• Untreated Illness = Brain On Fire
• Relapse & treatment resistance
• Increased mortality over time
• Suicide (most common cause of death in schizophrenia)
• Substance abuse
• Decreased quality of life
• Financial implications (unpaid balances, lose ins.)
• **BUT:** Some may do OK off meds

Morrissette & Stahl, 2012
Implications of Inadequate Partnership

Provider

• Non-adherence = hi liability risk
• Poor tx outcome can increase patient dissatisfaction
• Dissatisfied patients more likely to sue
• Lack of adequate Rx monitoring = greatest liability risk
• Increased staff time
• Negative financially
• Job dissatisfaction/burnout

Morrissette & Stahl, 2012

Implications of Inadequate Partnership

Economic
• 1 -10 days off meds increases 2x risk for inpt stay (schizophrenia)
• Hospitalization accounts for 2/3 cost of tx
• 40% of annual costs for re-hospitalization r/t non-adherence

Societal
• Role disruption at home, school, work (SDS)*
• Arrests
• Violence
• Victimization
• Occupational losses in manpower & productivity
• Health care costs

*Sheehan Disability Scale

Morrissette & Stahl, 2012
The Who’s & What’s in Aligned Partnership

✓ Patient
✓ Provider
✓ Severity of Illness
✓ Economics/Health Care System

From Patient’s Perspective

• How much does this illness affect me?
• Do I even have what they say I have?
• Do meds help? Have they ever helped?
• How bad are the side effects?
• How much extra stuff do I need to do?
• Can I afford it?
• Can I get there?
• How often do I have to go for appointments?
• Do I like the providers?
• Can I talk to them (including support staff)?
• Do they listen? Do they care?
• Is there really any help for me?
SEVERITY OF ILLNESS

- Altered thought processes
  - Delusions
  - Hallucinations
- Neurocognitive impairment
- Insight & judgment
- Comorbidity
  - Substance abuse
  - Personality disorders

(Foster, et al, 2011)

Degree of Difficulty To Produce Adherence Sufficient for Therapeutic Effect

(Keith & Kane, 2003)
THIS STUFF CAN KILL YOU!
*(this list is incomplete)*

- Clozapine
- Lithium
- Valproic acid
- Carbamazepine
- Olanzapine
- Alprazolam

- Clozapine - neutropenia, agranulocytosis, death
- Lithium - toxicity & death, renal & thyroid, drug interaction risks (diuretics, ACE inhibitors, NSAIDS), aplastic anemia
- Valproic acid - hyperammonemia, hepatitis, pancreatitis, fatty liver, PCOS, death
- Carbamazepine - drug rash w/eosinophilia & systemic symptoms (DRESS), SJ syndrome (also lamotrigine), bone marrow depression, death
- Olanzapine - 23 deaths among 289 hyperglycemia cases *(Koller & Doraiswamy, 2002)*
- Alprazolam - addiction, respiratory depression, death
But Antidepressants Are “Safe” . . .

Bupropion -- seizures, 1 case neonatal hyperinsulinemia, neutropenia

Citalopram - QTc prolongation

Sertraline, fluoxetine, mirtazapine - neutropenia


May Not Kill Me, BUT . . .

✓ Drooling
✓ Tremors
✓ Metallic taste
✓ Medicine head
✓ Out of control appetite
✓ Weight gain
✓ Fatigue
✓ “I have no emotion”
✓ Sexual dysfunction
WE HAVE MET THE ENEMY & HE IS US
TOP 6 REASONS PATIENTS STOP MEDS

- AKATHISIA (Abilify 25% Seroquel 0-4%)
- SEDATION (Seroquel 50%+)
- WEIGHT GAIN (1 in 6 gain more than 7%)
- SEXUAL SIDE EFFECTS (SS-SNRI)
- COGNITIVE DULLING
- EMOTIONAL BLUNTING

LIFE HAPPENS!
The Patient’s World

- Family/Friends/SO unsupportive (or no longer able)
- No phone (i.e., homeless)
- Housing
- Job restrictions or schedules
- Baby sitting limited or non-existent
- Sandwich generation duties
- Transportation
- Money
Economics/Health Care System

- No insurance
- Co-pays & deductibles
- Dx is not “priority population” eligible
- Medically indigent (insured but no MH benefit)
- Limited formulary
- Access to services/providers geographically limited or non-existent

PROVIDER/PATIENT FIT
Economics

WHAT ON THIS LIST CAN YOU “SKIP”?

- Psychotherapy visits
- Med management visits
- Labs, other testing
- IOP/PHP/Inpatient
- Other medical w/u PRN (e.g., Derm, Neuro)
The Provider as Partner

- Discuss personal life & treatment goals with patient (GOALS)
- Assess & consider actions necessary to achieve goals (ACTION)
  - Consultant/problem solving/coaching approach needed in attempt to overcome barriers
- Are goals feasible? Communicate honestly.
- Set out on the plan (INITIATE)
- Monitor, re-evaluate, discuss how it’s going, change course as needed (Nurture)

The Provider as Partner

- Per Stahl, find a med with efficacy, some tolerability, & stick with it!
- Keep dosing regimens as simple as possible
- Depot formulations as appropriate
- Write instructions down (or email if appropriate)
- Psychoeducation -- builds insight; can lower relapse
- Provide or refer for psychotherapy
- Work with the family/support system (if there is one)
- Care coordinators (ACT type interventions)
- Reminders via cell phone (Burda & Duarte, 2012)
P450 Technology

• Genotyping tests now available commercially

• Cheek swab or blood test

• Often not covered by insurance ($500+)
• Must educate patient does not predict efficacy

• More evidence needed to determine whether use is cost-effective & improves outcomes r/t adverse drug reactions or identifying poor responders

(Lynch & Price, 2007; Fleenan et al, 2011)

How The Hopper Group Defines Partnership

• Uses available scientific evidence & generally recognized standards of care for tx planning.

• Provides individualized tx planning.

• Discusses treatment options, risks, benefits, & alternatives (documentation shortcut “RBA”)

• Develops & communicates POC including pt. preferences.

• Explains when preferences are not clinically reasonable or c/w recognized standards of care.

• Discloses if or when the doc-pt tx relationship needs to end.

• Provides referral resources.
The Patient as Partner

• Discloses symptoms & problems, how they affect functioning at home, work, & in relationships.
• Communicates preferences & goals for tx.
• Understands options, both benefits & downsides, & asks questions.
• Follows the tx plan.
• Reports progress or lack of progress.
• Discloses problems or concerns so adjustments can be made.
• Keeps appts & meets financial responsibilities.
• Agrees to tx plan regarding use of drugs or ETOH.
• Informs of hospitalizations or changes in medical condition.
• Does not harm self or others.
• Informs of desire or intent to no longer receive tx.

CAUTION

“. . . shared decision-making models, when applied systematically by many people, may both stimulate a health care system driven by consumer demand rather than set standards of health care quality . . . (and adherence to such care and treatment) . . . in the long run [can] negatively affect the health status of the population.”

Sandman, et al. p. 35

(Super Bugs  Societal impact of pain med abuse)
REALITY

While the professional can be inventive in trying to match the patient’s preference to available minimally reasonable treatment standards, the patient “. . . will be facing the autonomous choice between accepting the treatments that can be offered . . . , or receiving no treatment at all.”

Sandman, et al, p. 37

BOUNDARIES

Patients are not allowed to influence [the minimally reasonable treatment standard] and professionals are not licensed to go below it.

Sandman, et al, p. 36
the best partnerships can last a lifetime
MEDICATION MANAGEMENT AGREEMENT

Patient: _______________________________________   Date: _______________

Medications:  ________________________________________________________
____________________________________________________________________

The purpose of this agreement is:
1. To prevent misunderstandings about the use of medicines prescribed to me including but not limited to controlled substances.
2. To promote compliance with state and federal laws regarding the prescription of dangerous or controlled substances.

1. I understand this agreement is essential to the trust and confidence necessary in a doctor/nurse practitioner-patient relationship that is entered into voluntarily by me for the purpose of receiving medical treatment.

2. I understand if I do not follow this agreement, my medications may be limited in quantity or no longer prescribed. If current medicines are not going to be prescribed the clinician, as clinically indicated, may offer a taper schedule or a referral to a hospital to manage withdrawal symptoms. Depending on the substance, withdrawal can have serious, potentially deadly, medical risks.

3. A chemical dependency treatment program may be recommended and information regarding where to obtain such services can be provided.

4. I will communicate fully with the treatment team about the character and intensity of my symptoms, any effect the symptoms are having on my ability to go about my daily activities, and how well the medicine is relieving my symptoms.

5. I will not use any illegal substances including but not limited to marijuana, cocaine, amphetamines, heroin, hallucinogens, club drugs, or prescription medicines obtained illegally.

6. I will not obtain any prescription or street available dangerous or controlled medicines, including narcotic (opioid) pain medicines, sedatives, controlled stimulants, and anti-anxiety medicines from any other prescribing clinician. If such medicines are
medically necessary, I will inform Practice Name of the prescriber, the reason, and length of time they are needed. Practice Name may contact the prescribing clinician to verify the information.

7. I will not share, sell, or trade my medicine.

8. I will safeguard my medicine from loss or theft. Lost or stolen medicines will not be replaced.

9. I agree that refills of prescriptions will be made only at the time of an office visit or during regular office hours. No refills will be available after regular business hours, in the evenings, or over weekends or office observed holidays.

10. I will select a pharmacy to fill my medicines and inform Practice Name if I change pharmacies. At this time I will use:

Pharmacy Name: __________________________ Phone: _____________

Location: _______________________________________

11. I authorize Practice and my pharmacy to fully cooperate with any city, county, state, or federal law enforcement agency, including the state’s Board of Pharmacy, Medicine, or Nursing, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize Practice Name to waive any applicable privileges or right of privacy or confidentiality that I have with respect to these authorizations.

12. I will keep follow up appointments as directed by the prescribing clinician.

13. If do not follow this agreement the Practice Name may end their treating relationship with me. I will be given _____ days notice after which time no further treatment services will be provided to me.

14. This agreement has been reviewed with me and I have had my questions answered.

Date: ________________________________

Patient Signature: ____________________________________________________

Initials: ____ A copy of this agreement has been provided to me.

Clinician Signature: __________________________________________________


