



ADVANCING INTEGRATED HEALTHCARE

Medicaid Recovery Behavioral Health ECHO®

Session Topic: Medication Management

Presenter(s): Jill Welte, MD MSW and Caitlin Kennedy, PharmD, MHA

Date: 5/24/2023

PLEASE NOTE: Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a project ECHO setting

Care Transformation Collaborative of RI

Welcome

- This session will be recorded for educational and quality improvement purposes
- Please do not provide any protected health information (PHI) during any ECHO session

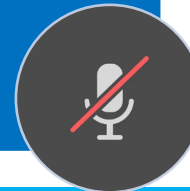
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Introduce Yourself



- Please mute your microphone when not speaking

Microphones



- Introduction
- Lecture
- Case
- Discussion
- Close

Agenda



CME Credits

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- CME Credits – Please request session credits when filling out the evaluation at the end of the meeting.
- Evaluation/Credit Request Form:
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Agenda

Time	Topic	Presenter
7:30 – 7:35 AM	Faculty Introduction	Liz
7:35 – 8:00 AM	Didactic Presentation	Jill Welte, MD MSW Caitlin Kennedy, PharmD, MHA
8:00 - 8:10 AM	Case Presentation	Mary E. Murray, MD
8:10-8:25	Case Discussion	Group
8:25 – 8:30 AM	Wrap up; Evaluation; Announcements	Susanne

Today's Faculty

- Dr. Jill Welte is a board-certified Child and Adolescent Psychiatrist and the Behavioral Health Medical Director for Coastal Medical Physicians. Dr. Welte obtained her Doctor of Medicine from the University of Missouri- Columbia and her Master of Social Work from New York University. Since 2017, Dr. Welte pioneered Coastal's integrated behavioral health strategy and developed our Pediatric Integrated Behavioral Health program. Dr. Welte currently provides direct clinical care to patients, consultative support to Coastal pediatricians, and clinical supervision for our adult and pediatric behavioral health clinicians. In addition to her clinical work, Dr. Welte leads care innovation projects such as Coastal's Pediatric Behavioral Health Remote Patient Monitoring program and virtual educational seminars for parents and families.
- Dr. Caitlin Kennedy is the Director of Pharmacy for Coastal Medical Physicians. Caitlin obtained her Doctor of Pharmacy from the University of Rhode Island and her Master of Healthcare Administration from George Washington University. Caitlin is dedicated to improving care delivery systems and enhancing the role of clinical pharmacists in value-based care models. In her current role, Caitlin oversees a dynamic team of pharmacists and pharmacy technicians integrated into many population health management initiatives. Most recently, Caitlin implemented a new model of clinical pharmacy delivery and continues to innovate new solutions and systems to reduce medication-related costs and promote safe and effective medication utilization.

Disclosures

Drs. Welte and Kennedy have no financial relationships with a commercial entity producing healthcare-related products used on or by patients.

If CME credits are offered, all relevant financial relationships of those on the session planning committee have been disclosed and, if necessary, mitigated.



ADVANCING INTEGRATED HEALTHCARE

Pharmacologic Management of Anxiety and Depression in Pediatrics

A Practical Guide

Care Transformation Collaborative of RI

Learning Objectives

- Understand indications for use of medication for anxiety and depression in the general pediatric population
- Overview common medications used to treat anxiety and depression
- Review basic principles of prescribing including titration, monitoring, and discontinuation

Deciding When To Prescribe



Establish a Working Diagnosis and Plan

Obtain thorough clinical history



Establish if symptoms meet criteria for DSM 5 diagnosis



Ensure symptoms cannot be accounted for by another condition



Consider pharmacologic, psychotherapy, and social treatment options

Medication, Psychotherapy, or Both?

- Randomized controlled studies in both pediatric anxiety (CAMS) and depression (TADS) conclude that combining SSRI + CBT treatments results in earlier and more robust response to care
- In both studies, SSRI and CBT monotherapy each showed significantly better response rates compared with placebo
- By the end of the trials, monotherapy response rate caught up with combined therapy
- **BOTTOM LINE: Combined treatment is ideal, however initiating any evidence-based treatment is better than doing nothing.**

Consider Medical Comorbidities

- Managing mental health concerns improves adherence to treatment plan for chronic medical conditions
- Rare that a pediatric medical condition itself would be a contraindication to using antidepressant medications
 - Helpful to get input from the medical subspecialist managing care
- May need to consider drug-drug interactions with non-psychiatric medications



Common SSRI/SNRI Drug Interaction Concerns

Non-Steroidal Anti-Inflammatory drugs (NSAIDs)

- Ibuprofen
- Diclofenac
- Naproxen

Psych/Neuro Medications

- Stimulants
- Triptans
- Other anti-depressants

OTC/Other

- St. John's Wort
- Alcohol



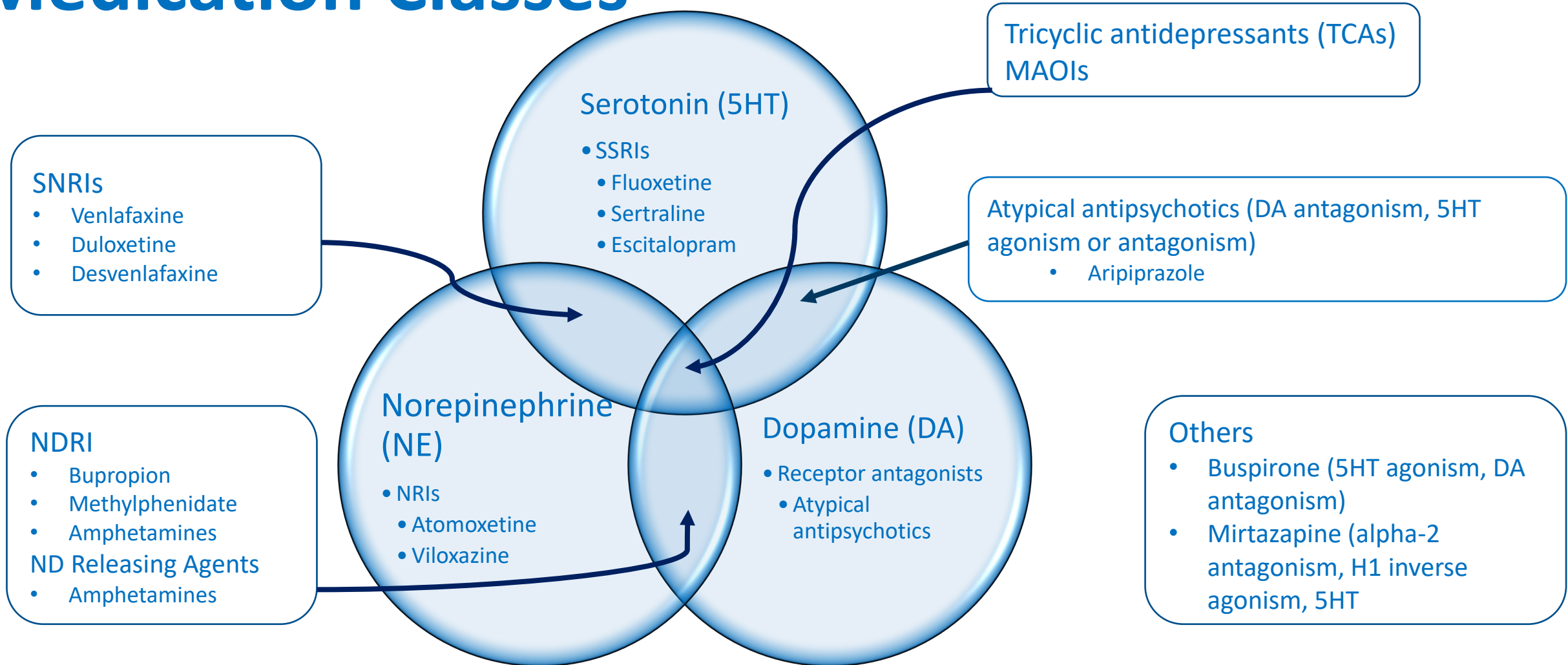
Deciding to not prescribe : New Medication

- Does not meet criteria for a DSM 5 diagnosis for which medication is indicated
- Patient or caregiver disagrees with plan
- Unable to complete recommended follow-up



Choosing a Medication

Medication Classes



Medication Selection



- SSRIs preferred as first-line treatment
- Some role for SNRIs however less evidence for use in pediatric populations
- Consider whether a relative has had a positive response to a specific medication
- Other considerations
 - Long vs short acting
 - Side effect profile

Medications with FDA Pediatric Indications

Medication	FDA Indications
Fluoxetine (Prozac)	OCD: 7 and older MDD: 8 and older
Sertraline (Zoloft)	OCD: 6 and older
Escitalopram (Lexapro)	MDD: 12 and older
Duloxetine (Cymbalta)	GAD: 7 and older

Off-Label Use of SSRIs and SNRIs

- Few FDA on-label indications in the pediatric population so prescribing is frequently off-label
- Extrapolate from other data :
 - SSRIs all have FDA indications for MDD ages 18+
 - Most SSRIs have FDA indications for at least one anxiety disorder ages 18+
 - Sertraline and fluoxetine have safety data to ages 6 and 7, respectively

Talking with the Patient and Family

Informed Consent



Provide education to patient and family on diagnosis, and treatment options and recommendation



Discuss potential risks and expected benefits with patient and family



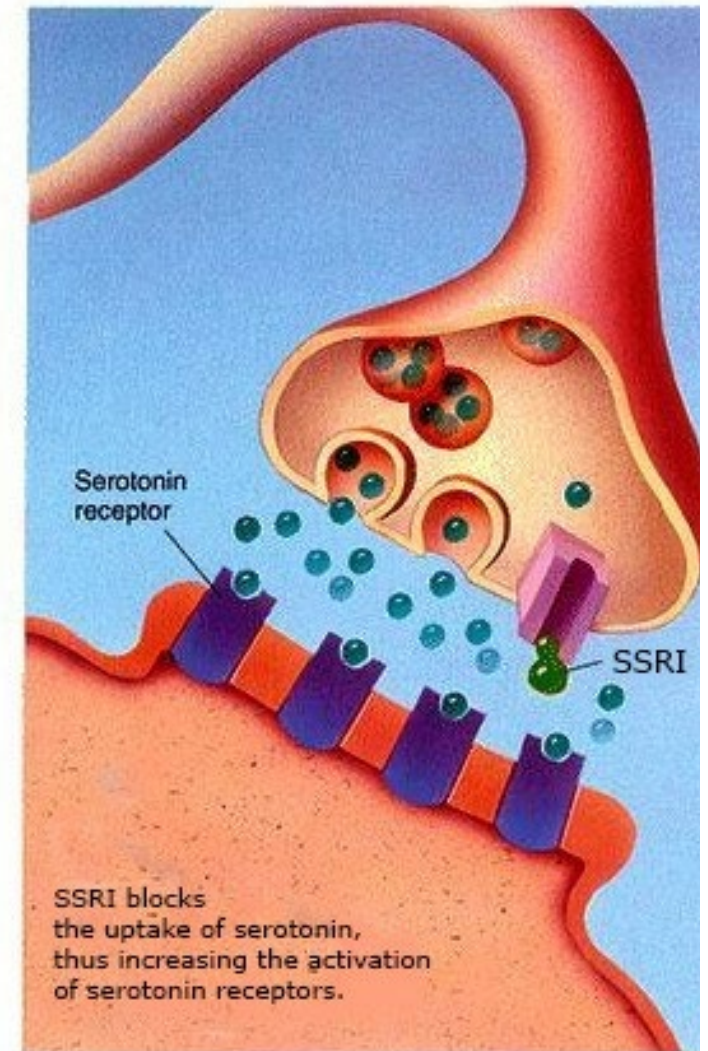
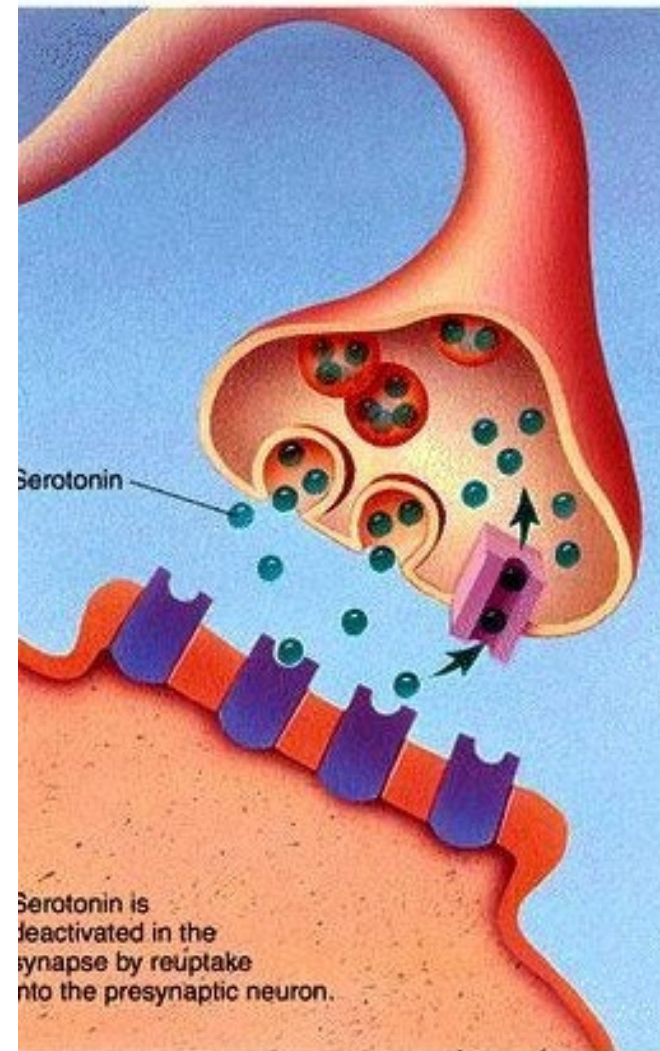
Obtain caregiver consent and patient assent for a trial



Provide counseling on potential medication side effects

Mechanism of Action

- Physiologic process:
 - Presynaptic neurons release monoamines into synapse which selectively bind to postsynaptic receptors
 - Reuptake transporters bring unbound monoamines back into presynaptic neurons for recycling and re-release
- With SSRI/SNRI intervention:
 - Medication selectively blocks reuptake transporters
 - Increased relative availability of monoamine in the synapse -> increased activation of existing receptors and upregulation of new receptors



“How do SSRIs work?”

- The brain is an electrical circuit with many signaling pathways
- Depression and anxiety share a pathway influenced by serotonin. Symptoms develop when signaling is disrupted
- Medication gives serotonin more chances to find a landing spot to keep the signal going strong
 - NOT A CHEMICAL IMBALANCE
 - No increase in amount of serotonin produced
- Serotonin is most abundant in the brain, GI tract
 - Responsible for somatic symptoms and side effect profile



Activation vs Mania

SSRI-Induced Activation Syndrome

- Increased symptoms of restlessness, mood lability, agitation, anxiety
- Typically emerges in the first few weeks of treatment
- Higher risk for SI
- Reversible by stopping SSRI

SSRI-Induced Mania

- Development of classic manic symptoms: marked reduction in need for sleep, increase in goal-directed behaviors, pressured speech, grandiosity, risk-taking behaviors
- Emerges within first few days or weeks of treatment
- Reversible by stopping SSRI

FDA Black Box Warning - 2004

PROZAC®
FLUOXETINE CAPSULES, USP
FLUOXETINE ORAL SOLUTION, USP
FLUOXETINE DELAYED-RELEASE CAPSULES, USP

WARNING

Suicidality and Antidepressant Drugs — Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Prozac or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Prozac is approved for use in pediatric patients with MDD and obsessive compulsive disorder (OCD). (See WARNINGS, Clinical Worsening and Suicide Risk, PRECAUTIONS, Information for Patients, and PRECAUTIONS, Pediatric Use.)

- Based on meta-analysis of 24 RCTs across all antidepressant classes
- Small but significant increased risk of suicidal thoughts or self-injurious behavior
- Subsequent analyses reflect multiple flaws in study design which impact whether risk is significantly different from placebo

Reviewing Risks and Benefits

	NNT	NNH
MDD	3-10	100
Anxiety Disorders	5	200
OCD	3	140

- Weigh risks of both using and not using medication
- Suicide attempts and completions significantly higher in untreated depression
- For every case with a SSRI-induced SI/self-injury event, 11 patients show response

Starting and Monitoring Medications

Initiation and Titration

- Start low to limit side effects
- Progress dose every 2-3 weeks if tolerating well
- Hold dose when desired clinical effect is reached
- Plan to continue titration if having breakthrough symptoms

Defining a “good trial”

- Titration to maximum dose tolerated by patient and/or top of the recommended dosing range
- For at least 6-8 weeks



FDA Recommended Follow Up Schedule



Weekly for the first 4 weeks following initiation of medication



Every 2 weeks for the next 4 weeks



At 12 weeks



As clinically indicated after 12 weeks

- Follow up can be by video, phone, or office visit
- Can be a quick check-in rather than full appointment
- Does not have to be with prescribing physician. Use available resources:
 - Outpatient therapist
 - IBH clinician
 - Nurse care manager

Defining Outcomes

Response	No symptoms or a significant reduction in depressive symptoms for at least 2 weeks
Remission	A period of at least 2 weeks and less than 2 months with no or few depressive symptoms
Recovery	Absence of significant symptoms for 2 or more months (eg, no more than 1-2 symptoms)
Relapse	DSM-defined episode occurs during remission period
Recurrence	New DSM-defined episode starts while in recovery phase



Deciding to not prescribe: Increase/Change

- Concern for adverse effects at current dose
- Poor/sporadic adherence to dosing schedule
- No engagement in non-pharmacologic interventions





Changing Medication

Change may be warranted when patient has not achieved response/remission from a good trial of a medication

Conservative Switch

- Taper Med 1 by 25% of original dose in 1 week intervals
- Initiate starting dose of Med 2 a few days after Med 1 has been discontinued

Cross-titrate

- Gradual reduction of Med 1 to discontinuation
- Introduction of Med 2 at starting dose during the taper and titrate to treating dose
- Make one change per week, alternating between taper and titration

Direct switch**

- Estimate Med 1 to be in low/middle/upper range of recommended dosing
- Estimate rough equivalent of Med 2 based on dosing range
- Start Med 2 with next dose

**only use when half-lives are similar

Planned discontinuation

- To reduce risk of relapse, continue medication 6-12 months after reaching remission before starting a taper
- Taper in increments of 25% of treating dose
 - Recommendations vary from 1-4 weeks between intervals
- Consider timing!
 - Wait until after any anticipated transitions such as transition to HS or college
 - Summer is least impactful on school performance, however overall symptom burden may naturally be lower

Supplemental Slides



DSM 5 Diagnoses which warrant consideration of SSRI/SNRI treatment	DSM 5 Diagnoses typically not warranting medication
Mood Disorders	
Major Depressive Disorder (moderate to severe) Unspecified Depressive Disorder	Persistent Depressive Disorder (dysthymia) Major Depressive Disorder (mild)
Anxiety Disorders	
Generalized Anxiety Disorder Separation Anxiety Disorder Social Anxiety Disorder Panic Disorder Unspecified Anxiety Disorder	Specific Phobia
Other	
Obsessive Compulsive Disorder	Adjustment Disorders

Medications with FDA Pediatric Indications

Medicine + FDA Indications	Dosing	Benefits	Drawbacks
Fluoxetine (Prozac) OCD: 7 and older MDD: 8 and older	Starting: 10mg daily Treating: 20-60mg daily (80 in adults) Titration increments of 10-20mg	Longer half-life- no discontinuation syndrome Daily dosing More activating Tablet, capsule, liquid	Longer half-life- prolonged adverse effects Limited dosing intervals
Sertraline (Zoloft) OCD: 6 and older	Starting: 12.5-25mg daily Treating: 50-200mg daily Titration: increments of 12.5-25mg	Shorter half-life Daily dosing Wide dosing flexibility Tablet, liquid	More GI side effect complaints Risk of discontinuation syndrome
Escitalopram (Lexapro) MDD: 12 and older	Starting: 5mg daily Treating: 10-20mg daily Titration: increments of 5mg	Shorter half-life Daily dosing Well-tolerated Tablet, liquid	Limited dosing intervals Risk of discontinuation syndrome
Duloxetine (Cymbalta) GAD: 7 and older	Starting: 20mg daily Treating: 20-60mg daily Titration: increments of 20mg	Shorter half-life Daily dosing	Limited dosing intervals High risk of discontinuation syndrome Capsule only

Treatment of Adolescent Depression Study (TADS)- 2007

Study Design

- 36 week multisite RCT (n= 327) evaluating effectiveness of fluoxetine (FLU) vs CBT vs combined treatment (COMB) in adolescents ages 12-17 with MDD

Outcomes: Treatment Response (%)

	Week 12	Week 18	Week 36
COMB	73	85	86
FLU	62	69	81
CBT	48	65	81

Conclusions

- FLU or COMB accelerates response to treatment
- Adding CBT to medication enhances safety (lower rates of SI or suicidal events in both CBT arms)
- COMB is superior to either monotherapy

Child/Adolescent Anxiety Multimodal Study (CAMS)- 2008

Study Design

- 12 week multisite RCT (n= 488) evaluating effectiveness of sertraline (SER) vs CBT vs combined treatment (COMB) in youth ages 7-17 with GAD, Separation Anxiety Disorder, or Social Anxiety Disorder

Outcomes: Treatment Response (%)

	Week 12	Week 24	Week 36
COMB	80.7	85	86
SER	54.9	69	81
CBT	59.7	65	81
PBO	23.7		

Conclusions

- COMB or monotherapy all superior to placebo
- COMB superior to either monotherapy
- No difference ($p = 0.41$) between monotherapies
- Follow up study at 24 and 36 weeks shows sustained improvement, with COMB still superior

Child/Adolescent Anxiety Multimodal Extended Long-Term Study (CAMELS)- 2018

Study Design and Outcomes

- Long-term follow up to CAMS (n= 319) examining remission across a 4 year period acute treatment phase
 - 22% stable remission
 - 30% chronically ill
 - 48% relapsers
- Acute treatment responders were less likely to be chronically ill

2022 Follow Up Analysis

- 2022 study examined outcomes to participants in the original CBT arm
- Of the non-remitters (n= 90), 10 initiated pharmacotherapy after the 12 week acute treatment phase
- Those who did start medication showed significant improvement in symptoms compared to those who did not

Serotonin Syndrome

- Life-threatening syndrome that may result from concomitant use of multiple medications that increase serotonin levels
- Characterized by rapid onset of mental status changes, autonomic dysfunction, and dystonias
 - Symptoms can include agitation, tachycardia, hypertension, hyperthermia, hyperreflexia, tremor, nausea, vomiting
- Management in primary care
 - Discontinue all potential offending medications
 - If few symptoms and they are mild, watchful waiting
 - If multiple symptoms and/or moderate to severe, direct to emergency department for evaluation and management

BOTTOM LINE: Start low, go slow, only one change at a time

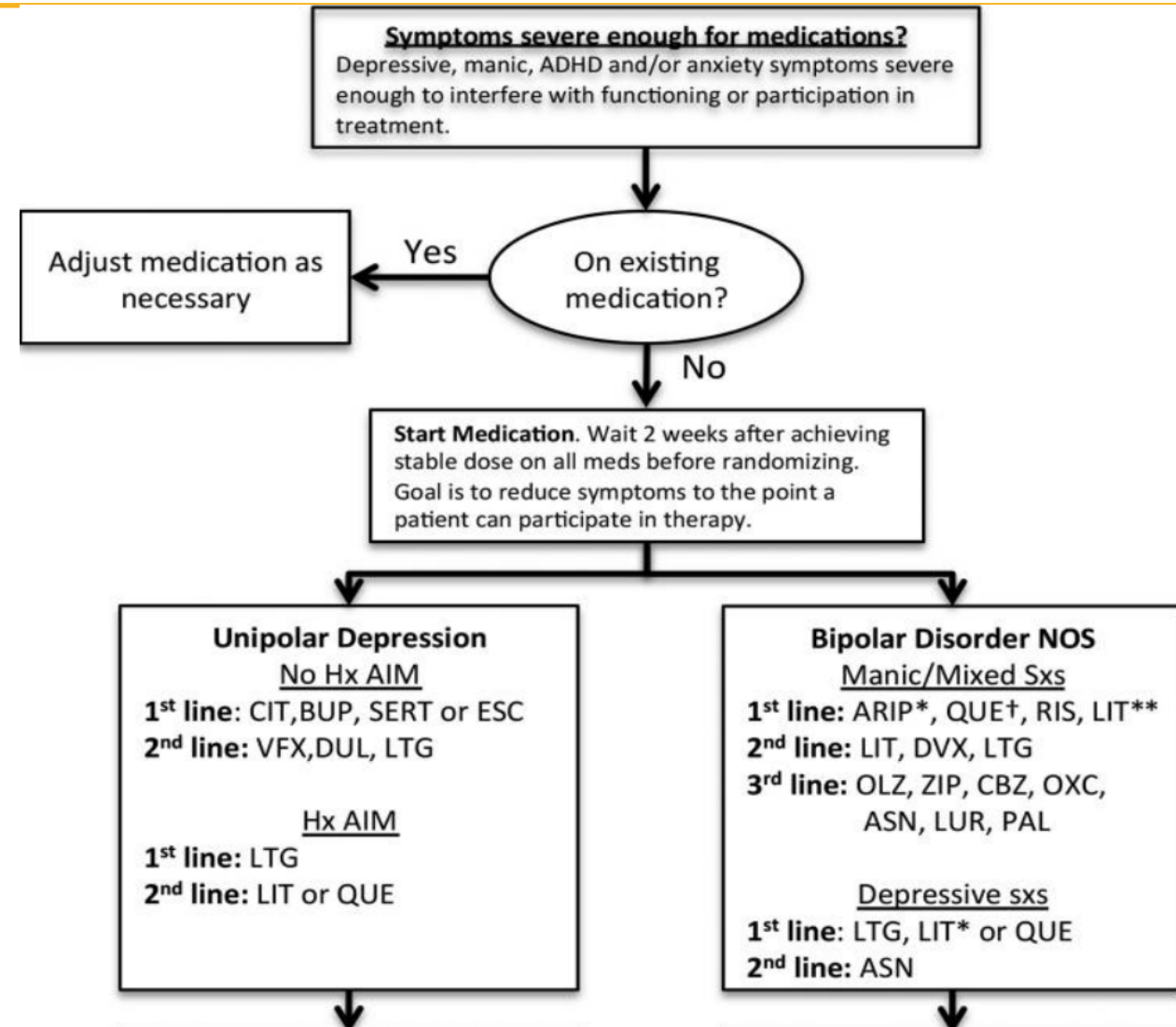
Serotonergic Medications	
Psychiatric	Non-Psychiatric
SSRIs	Dextromethorphan
SNRIs	Triptans
TCA's	Linezolid
MAOIs	Ritonavir
Atypical antidepressants (mirtazapine, trazodone, buspirone, etc)	Analgesics (codeine, fentanyl, hydrocodone, oxycodone, tramadol)
Atypical antipsychotics (risperidone, aripiprazole)	Herbal supplements (St. John's Wort, ginseng)
Lithium	Anti-emetics (ondansetron, metoclopramide)

Discontinuation Syndrome

- Can occur when SSRI/SNRI dose is decreased or medication is stopped
 - Neuronal response to downregulated post-synaptic serotonin receptor activity
 - Can start 1-10 days after taper or discontinuation
 - Paroxetine and SNRIs are the worst offenders
 - Unlikely to occur with fluoxetine due to long half-life
- “FINISH:” flu-like symptoms, insomnia, nausea, imbalance, sensory disturbances, and hyperarousal (anxiety/agitation)
- Management recommendations:
 - Return to previous dose, restart the taper at a slower pace
 - In select cases, may switch to fluoxetine and taper off of that

Treating in Context of Parental History of Bipolar Disorder

- Obtain thorough clinical history including assessment of any personal history of mania
- Treat the symptoms that have been or are currently present
- Monitor for any emergence of activation or anti-depressant induced mania (AIM)



Schneck et al. J Child Adolesc Psychopharmacol. 2017 Nov 1; 27(9): 796–805



ADVANCING INTEGRATED HEALTHCARE

Medicaid Recovery Behavioral Health ECHO® Case Presentation

Presenters: Mary E. Murray, MD

Date: 5/24/2023

Contact Info: mmurray7@lifespan.org

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Stop Recording

Reasons for Selecting this Case

Do Not Include PHI

Why did you choose this case?	<p><i>Pt is now 17, but presented 2/2020, age 14, with significant sx's of depression but declined therapy and medication</i></p> <p><i>After two years of regular discussions with me, we have finally worked together to come up with a medication plan</i></p> <p><i>I found it very challenging to get patient to agree to work on her own mental health. There was also the challenge of getting both parents to agree to the care</i></p>
What questions do you have for the group?	<p><i>How do you deal with a depressed patient who declines therapy or psychiatric care?</i></p> <p><i>How to deal with divorced parents with different opinions</i></p>

Basic Patient and Family Information

Do Not Include PHI

Age / Grade	17, Junior (started as a freshman)
Gender Identity	female
Race/Ethnicity	
How long has this individual been in your care?	<i>Since age 12, I have been following her for c/o anxiety and depression 2/2020, age 14</i>
Insurance type	<i>United</i>
Family constellation	<i>Parents divorced; both remarried with young children; she has three half siblings on her mother's side and one half sibling on her father's Initially living primarily with mom and her family, now with dad and his family</i>
Parent(s)' occupation if known	

Relevant Medical Background and Screening *Do Not Include PHI*

Relevant medical and/or BH conditions, hospitalizations	<i>Patient has also identified some body image issues, weight has been stable. She has a history of migraines</i>
Relevant medications or medication hx	NA
Relevant lab results	NA
Relevant BH Screening results	<i>PHQ9 scores have ranged between 14-19</i> <i>She has always denied any suicidal thoughts, has had thoughts of self harm, primarily restricting</i>
Relevant SDOH Screening results	NA

Relevant Psychosocial History

Do Not Include PHI

Family/patient history of anxiety, suicidality, learning difficulties, other BH conditions?	<i>Maternal anxiety - on fluoxetine, MGM anxiety, PGM suicide</i>
Other relevant psychosocial factors?	<p><i>When patient initially presented she also mentioned comment her current boyfriend made that made her self conscious about her weight, she restricted, mom also noted that she appeared to have some anxiety about eating in front of others</i></p> <p><i>Parents have very different parenting styles; patient wanted to move to father's because there are fewer rules</i></p>

Patient / Family Strengths

Do Not Include PHI

Parents are both involved and concerned.

Patient has been willing to answer questions directly, is willing to keep frequent appts with PCP, she is willing to discuss issues openly

Relevant School Information

Do Not Include PHI

She initially presented **right before the COVID** lock down, when she was at home she tended to **self isolate**, was **not getting school work done**.

Things have **improved academically** - getting A's and B's - but she does identify **anxiety at school about getting lost at school** (during her freshman year) **or not having the answers when called on**.

What approaches have you used to help this patient?

Do Not Include PHI

We initially **discussed working with therapist**, she declined to see therapist outpatient, saying that therapy didn't work. **Referred to internal IBH** resources (both Ann Sullivan LICSW, who she saw twice, was somewhat cooperative but felt forced to talk, and Dr. Welte once, declined medication, concerned about weight gain)

Patient was **referred to Thundermist** for behavioral health consult but **refused to keep the appt**

At her 17 year appointment (3/2023) she identified that she was **only feeling happy 3% of the time** and was ready to make a change. **She agreed to start medication**. She still declined to work with a therapist or psychiatrists, so far **on fluoxetine 30 mg - she is seeing some mild improvement**

Summary & Clarifying Questions



Reasons for Selecting this Case

Do Not Include PHI

Why did you choose this case?

Pt is now 17, but presented 2/2020, with significant sx's of depression but declined therapy and medication

After two years of regular discussions with me, we have finally worked together to come up with a medication plan

I found it very challenging to get patient to agree to work on her own mental health. There was also the challenge of getting both parents to agree to the care

What questions do you have for the group?

How do you deal with a depressed patient who declines therapy or psychiatric care?

How to deal with divorced parents with different opinions

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Announcements

Next Session: Thursday, June 22, 2023 7:30-8:30

Topic: Suicide Risks / Prevention / Tools

Presenter: Sarah Hagin, PhD

Case Presentation: Care New England

Liz is available to consult on patient cases, as part of the Behavioral Health Technical Assistance offering from the Medicaid Recovery Program. (Liz.Cantor@gmail.com)

