# Clinical Practice Guideline:
# Management of Anxiety in Adults in Primary Care

Contents

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# I.   Overview

Behavioral health disorders are common in the primary care setting, and frequently co-exist with and worsen the outcomes of chronic diseases. These disorders are undertreated due to inadequate recognition, a shortage of behavioral health clinicians, stigma, and challenges navigating complex healthcare systems. Integrating behavioral health care into primary care provides a holistic care approach that reduces fragmentation, reduces time to treatment, destigmatizes behavioral health disorders, lowers care costs, increases patient and provider satisfaction, and improves both behavioral and physical health outcomes.

Dartmouth-Hitchcock is in the process of implementing behavioral health integration at its primary care clinics, utilizing the Collaborative Care Model- a team approach in which the patient and primary care provider (PCP) are supported by a Behavioral Health Clinician (BHC, usually a licensed clinical social worker) and a consulting psychiatrist. This process includes screening with a standardized questionnaire, eDH decision support triggered by positive screens, Knowledge Map guidelines, and training to address depression, anxiety, and unhealthy alcohol and drug use.

# II.   Guideline Source Material

There is no American guideline addressing the management of anxiety in primary care. This Knowledge Map guideline synthesizes the results of a literature review, drawing predominantly from 2 recent review articles[1,2] and local expert opinion.

# III.   Guideline Development Narrative

A literature review and initial draft were done by Knowledge Map. This draft was reviewed and revised by the psychiatry members of the advisory committee, and the resulting revision was reviewed by the primary care members of the advisory committee.

# IV.   Disclaimer

This guideline is not a substitute for clinical judgment. Guideline recommendations address care of populations; use clinical judgment and patient participation to tailor treatment plans to individual patients.

# V.   Recommendations

A. Screening and Diagnostic Evaluation

1. D-H primary care clinics should screen patients for anxiety, using the GAD-7 screening instrument.

    a. Although population screening for anxiety disorders is not routinely recommended, it may be beneficial if systems are in place to care for patients who screen positive.[2] The DH behavioral health questionnaire includes the GAD-2, which triggers the remaining questions of the GAD-7 [3] for a score over 3.

2. Patients with positive screens, those presenting with complaints of anxiety, and those presenting with medically unexplained symptoms should be evaluated:

    a. To distinguish normal anxiety from an anxiety disorder

    b. To distinguish physical illness from somatic complaints of anxiety

    c. To diagnose co-morbid psychiatric and substance use disorders

3. The most commonly encountered anxiety disorders in primary care (generalized anxiety disorder (GAD), panic disorder, and social anxiety disorder (SAD)) commonly co-occur, share much in common, and have similar treatments- arguing for a unified approach to screening, diagnosis and treatment [4]

4. The severity of anxiety should be measured with the full GAD-7 initially and at each follow-up visit to assess response to treatment.

B. Treatment

1. Treatment for anxiety is determined by severity, co-morbidity, patient preference, and available resources, stepping up care when needed.

    a. Initial treatment of milder symptoms can start with lifestyle interventions that are accessible, low cost, and safe: physical exercise, yoga, mindfulness based stress reduction (available through apps or web-based programs), and education.

    b. For more bothersome or persistent symptoms, cognitive behavioral therapy (CBT) or pharmacotherapy are equally effective (~50-60% response), and the initial treatment should be based on patient preference.

    c. Combination treatment works better in severe or treatment-resistant cases.

2. The most validated non-pharmacological treatment for anxiety is CBT.

    a. Online programs can be effective (on their own or as an adjunct to in-person counseling), and have advantages of cost, convenience and anonymity.[5-7]

3. Drug therapy for anxiety

    a. Selective serotonin receptor inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are the clear first-line agents due to a combination of efficacy and safety, and also treating co-morbid depression.

    b. Second line medications should be used in combination with SSRI/SNRIs if response is incomplete, or as monotherapy when SSRIs/SNRIs are not tolerated or minimally effective.

    c. Benzodiazepine use should be limited to patients without histories of alcohol or other substance use who have not responded to antidepressants and CBT, or as short-term bridging for severe symptoms. Long acting agents (e.g. clonazepam) are preferred, and should be taken on a scheduled basis. Chronic use is generally discouraged.

    d. Alternatives to benzodiazepines include scheduled pregabalin, buspirone (for GAD only) or as needed hydroxyzine.

    e. Marijuana use to self-treat mood and anxiety disorders may temporarily relieve symptoms, but is associated with worse outcomes in the long term[8] and should be discouraged.

C. Monitoring and Follow-up

    a. Response to treatment should be assessed with the GAD-7 at each visit and/or through between-visit telephone outreach by the Behavioral Health Clinician.[9]

    b. Treatment should be stepped up as described above until there is satisfactory relief of symptoms.

    c. Pharmacological treatment at the therapeutic dose should be maintained for 9-12 months, after which a slow taper may be considered.[10]

## VI.  Action Plan

A. Clinical Pathways/Workflows

- Screening workflow as part of the Collaborative Care Model roll-out
- BHC protocol: contact with patients, use of registry, supervision by psychiatrist

B. eDH Tools

- Screening questionnaire (as part of behavioral health bundle) administered pre-visit through myDH (home) and tablets (in clinic)
- Best Practice Advisory, triggered by GAD-7 score ≥10.
- Smartset attached to BPA, offering clinical decision support and ordering efficiency
- Smartphrase note templates to provide decision support and assist in documentation
- e-Consults: an efficient way to get input from a psychiatrist, delivered and recorded in the patient's chart

C. Clinician Education

- Archived talk available for CME, recorded 10/18/18: https://ce.dartmouth-hitchcock.org/Activity/6615505/Detail.aspx
- Clinician Guide (more narrative and detailed form of this guideline) (hyperlink to Clinician Guide when approved)
- Conferences, on-site talks, Project ECHO (Education for Community Health Outcomes) teleconference

D. Patient Education and Shared Decision Making

- List of self-management books, websites, and apps (available through smartset: patient information, smartphrase ".BHAPPS", and on SUMHI website)

E. Metrics

To be monitored by the SUMHI behavioral health integration team:

- % of eligible patients screened
  - Questionnaire answered in myDH vs. tablet
- % of patients screened who have a positive score (≥3 on GAD-2, ≥10 on GAD-7)
  - % of those with +GAD-2 who complete the GAD-7

- % of patients with GAD-7≥10 who have anxiety entered into problem list
- % of patients with GAD-7≥10 who are referred to BHC
- % of patients referred to BHC with successful and attempted contacts within 2 weeks
- Number of contacts over 4 mo from time of + screen
    - PCP appointments
    - BHC appointments
    - Consulting psychiatrist appointments
- % of patients with GAD-7≥10 with 50% reduction in GAD-7 score in 7 months
- Clinician satisfaction and confidence in treating anxiety (pre/post)

## VII.  References

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