DRAFT

Primary Care Consultation Psychiatry

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Primary Care Consultation Psychiatry

This series of six modules is designed to introduce a psychiatrist to the practice of primary care psychiatry. There is a special focus on the developing role of a psychiatrist functioning as part of a collaborative care team. Each module has stated objectives and a content slide set. The core topics are:

Module 1:	**Introduction to Primary Care Consultation Psychiatry**
Module 2	**Building a collaborative Care Team**
Module 3	**Psychiatric Consulting in Primary Care**
Module 4	**Behavioral Interventions and Referrals in Primary Care**
Module 5	**Medical Patients with Psychiatric Illness**
Module 6	**Psychiatric Patients with Medical Illness**

Module 3: Psychiatric Consulting in Primary Care

Learning Objectives: Module 3

By the end of this module, the participant will be able to:

- Discuss common behavioral health presentations in the primary care setting.
- Collaborate effectively with primary care providers and BHPs/care managers in a collaborative care team.
- Apply a systematic approach to psychiatric consultation for common behavioral health presentations in primary care.
- Demonstrate a primary care oriented approach to pharmacological treatment of common psychiatric disorders.
- Recommend treatment approaches for psychiatric crises and difficult patients.

Principles of Integrated Behavioral Health Care

Patient Centered Care

- Team-based care: effective collaboration between PCPs and Behavioral Health Providers.

Population-Based Care

- Behavioral health patients tracked in a registry: no one ‘falls through the cracks’.

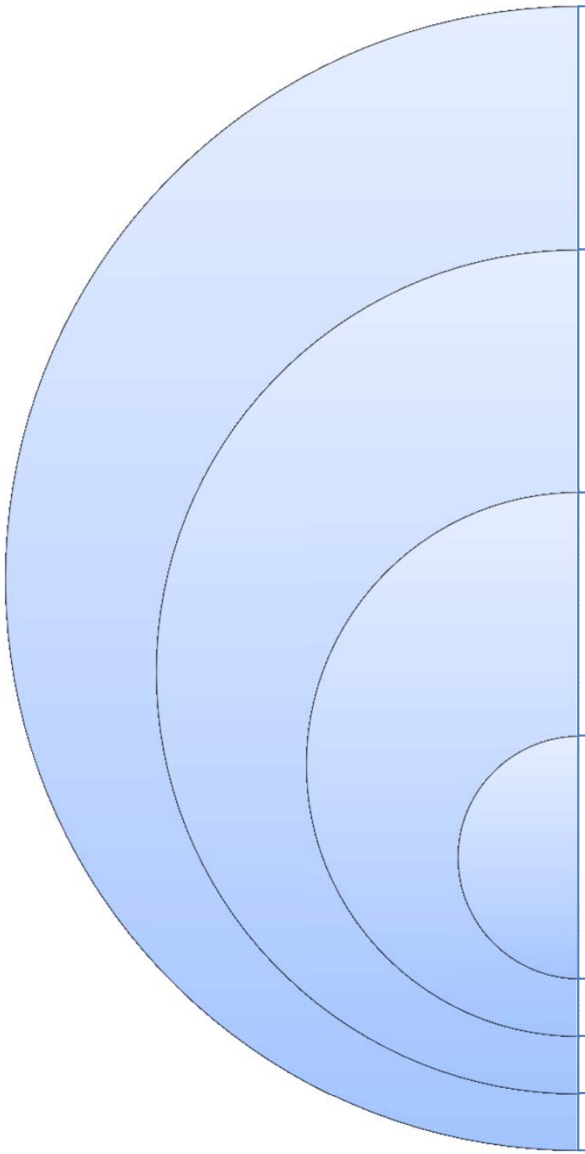
Measurement-Based Treatment to Target

- Measurable treatment goals and outcomes defined and tracked for each patient.
- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

- Treatments used are ‘evidence-based’.

Roles for Psychiatrists



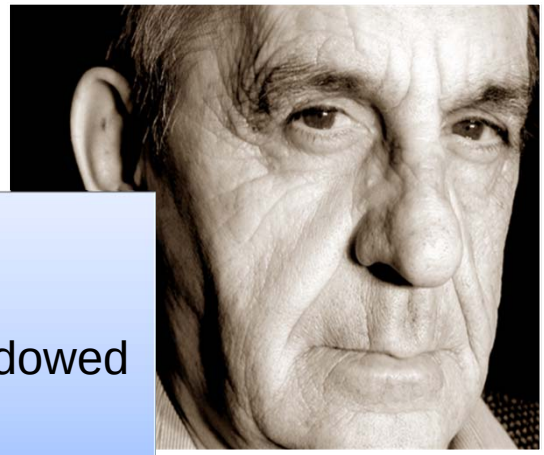
Clinical Leader	• Shape behavioral healthcare for a defined population of patients in primary care
Caseload Consultant	• Consult indirectly through care team on a defined caseload of patients in primary care
Direct Consultant	• Consult directly by seeing selected patients
Clinical Educator	• Train BHPs and PCPs • Both directly and indirectly

Scope of Practice

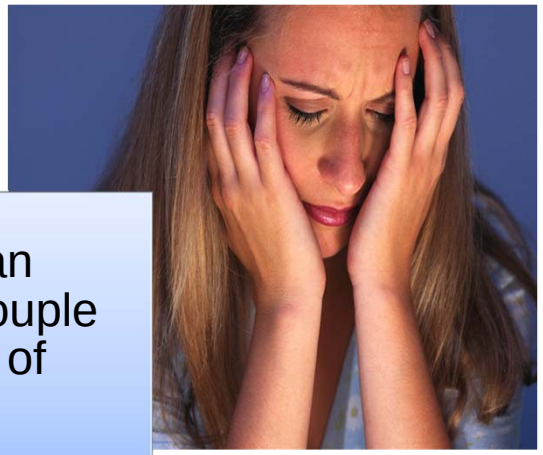
What is the environment in which you are consulting and are you comfortable providing support for all these populations?

- **Adults**
- **Children**
- **Pregnant patients**
- **Older Adults**
- **Chronic pain**
- **Substance use treatment**

What does a behavioral health patient look like in a primary care setting?

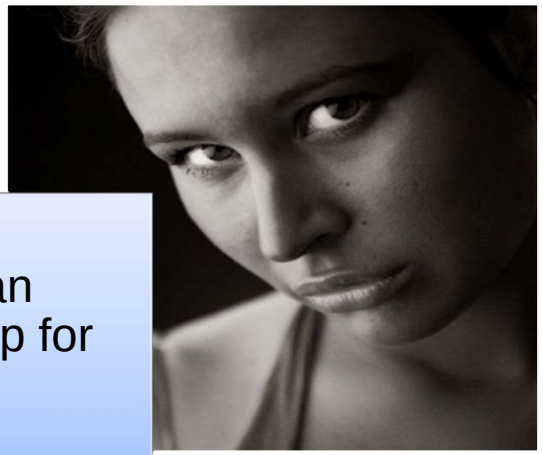


67yo man recently widowed



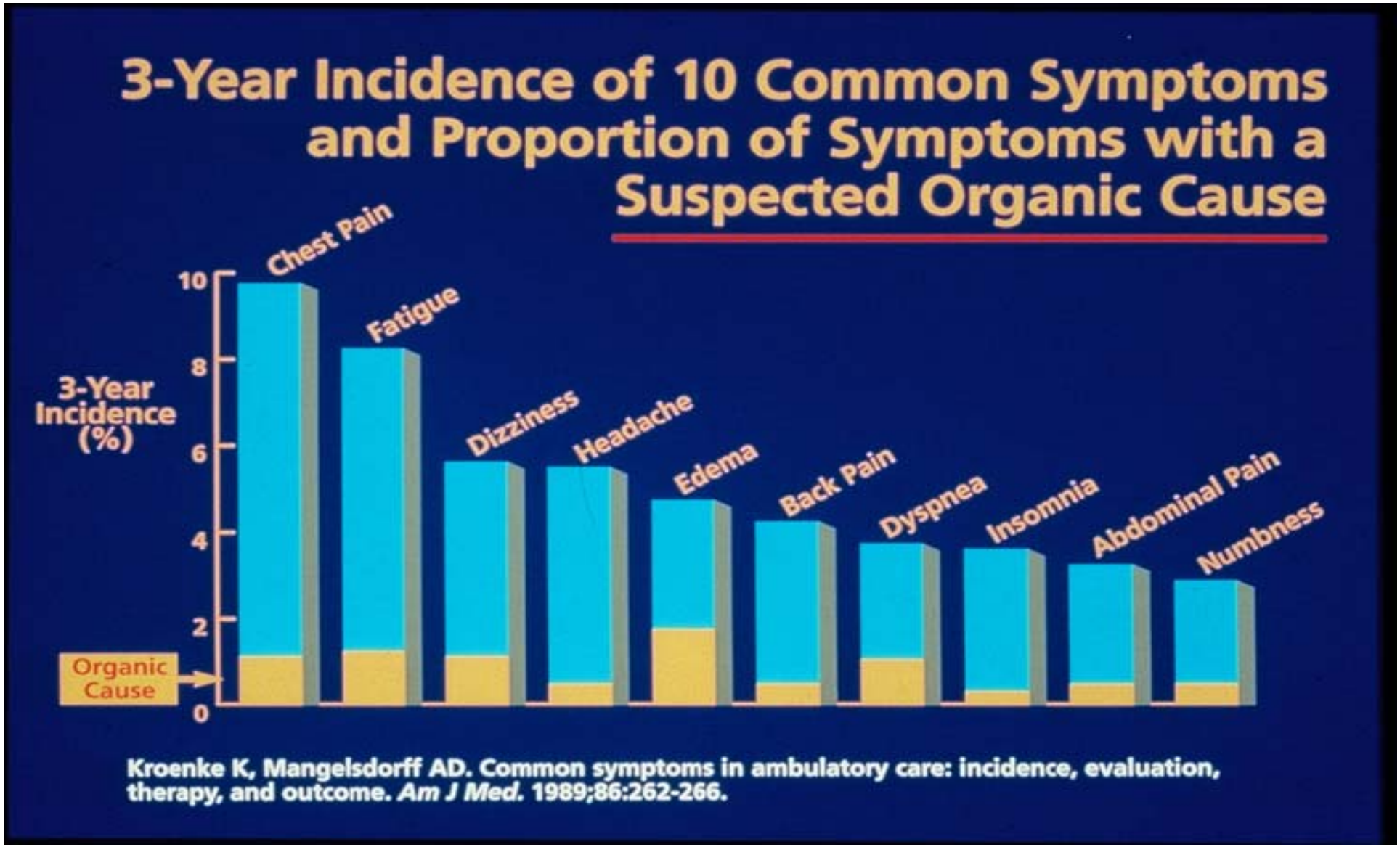
43yo woman drinks ”a couple of glasses” of wine daily

19yo man “horrible stomach pain” when starts college

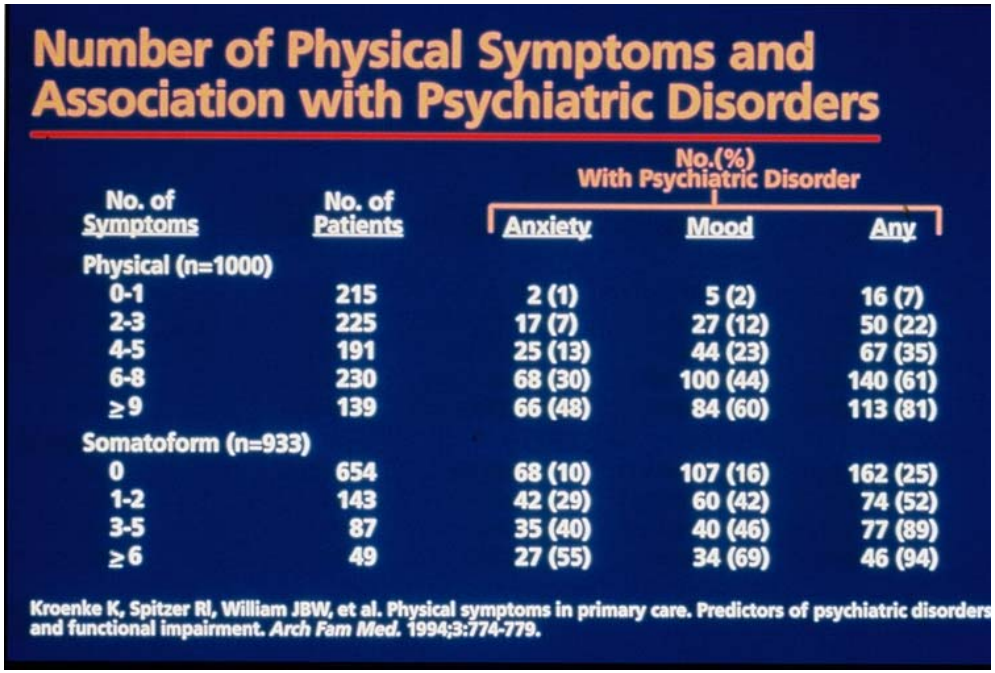


32yo woman “can’t get up for work”

Most symptom presentations do not have a clearly identified ‘organic cause’



The # of physical symptoms is strongly associated with likelihood of depression & anxiety



Number of Physical Symptoms and Association with Psychiatric Disorders

No. of Symptoms	No. of Patients	No.(%) With Psychiatric Disorder		
		Anxiety	Mood	Any
Physical (n=1000)				
0-1	215	2 (1)	5 (2)	16 (7)
2-3	225	17 (7)	27 (12)	50 (22)
4-5	191	25 (13)	44 (23)	67 (35)
6-8	230	68 (30)	100 (44)	140 (61)
≥9	139	66 (48)	84 (60)	113 (81)
Somatoform (n=933)				
0	654	68 (10)	107 (16)	162 (25)
1-2	143	42 (29)	60 (42)	74 (52)
3-5	87	35 (40)	40 (46)	77 (89)
≥6	49	27 (55)	34 (69)	46 (94)

Kroenke K, Spitzer RI, William JBW, et al. Physical symptoms in primary care. Predictors of psychiatric disorders and functional impairment. *Arch Fam Med.* 1994;3:774-779.

Common Behavioral Health Presentations

Common psychiatric presentations:

- Mood disorders
- Anxiety disorders
- Substance use disorders
- Psychotic disorders
- Cognitive disorders

Common primary care presentations:

- Depression
- Anxiety
- Unexplained physical symptoms
- Somatic presentations & somatoform disorders
- Acute and chronic distress
- Adjustment disorders
- Pain

Medical Specialties & their 'Problem Patients'

Orthopedics	Low back pain
Ob/Gyn	Pelvic pain, PMS
ENT	Tinnitus
Neurology	Dizziness, headache
Cardiology	Atypical chest pain
Pulmonary	Hyperventilation, dyspnea
Dentistry	TMJ syndrome
Rheumatology	Fibromyalgia
Internal Medicine	Chronic Fatigue Syndrome
Gastroenterology	Irritable bowel syndrome
Rehabilitation	Closed head injury
Endocrinology	Hypoglycemia
Occupational Medicine	Multiple chemical sensitivity

Behavioral Health Problems Complicate Medical Problems

Affect health behavior and decrease treatment adherence

Are associated with poor outcomes and mortality

→ See more in Module 5

Principles of Integrated Behavioral Health Care

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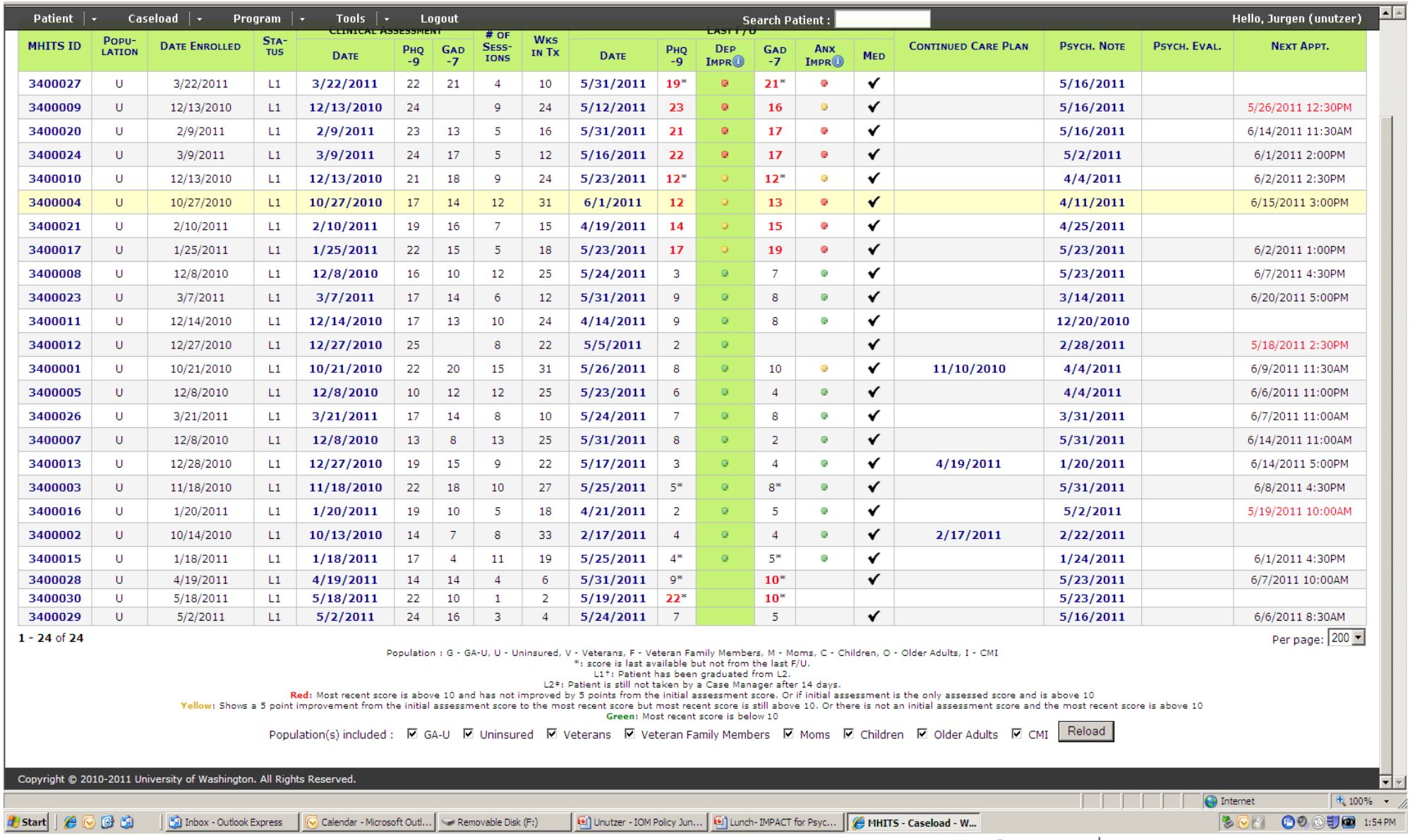
Caseload Summary: Prioritizing Cases to Review



Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment			# of Sess-ions	Wks in Tx	Last F/U						Continued Care Plan	Psych. Note	Psych. Eval.	Next Appt.
				Date	PHQ-9	GAD-7			Date	PHQ-9	Dep Impr	GAD-7	Anx Impr	Med				
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓		5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/12/2011	23		16		✓		5/16/2011		5/26/2011 12:30PM
3400020	U	2/9/2011	L1	2/9/2011	23	13	5	16	5/31/2011	21		17		✓		5/16/2011		6/14/2011 11:30AM
3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/16/2011	22		17		✓		5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓		4/4/2011		6/2/2011 2:30PM
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3400021	U	2/10/2011	L1	2/10/2011	19	16	7	15	4/19/2011	14		15		✓		4/25/2011		
3400017	U	1/25/2011	L1	1/25/2011	22	15	5	18	5/23/2011	17		19		✓		5/23/2011		6/2/2011 1:00PM
3400008	U	12/8/2010	L1	12/8/2010	16	10	12	25	5/24/2011	3		7		✓		5/23/2011		6/7/2011 4:30PM
3400023	U	3/7/2011	L1	3/7/2011	17	14	6	12	5/31/2011	9		8		✓		3/14/2011		6/20/2011 5:00PM
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3400012	U	12/27/2010	L1	12/27/2010	25		8	22	5/5/2011	2				✓		2/28/2011		5/18/2011 2:30PM
3400001	U	10/21/2010	L1	10/21/2010	22	20	15	31	5/26/2011	8		10		✓	11/10/2010	4/4/2011		6/9/2011 11:30AM
3400005	U	12/8/2010	L1	12/8/2010	10	12	12	25	5/23/2011	6		4		✓		4/4/2011		6/6/2011 11:00PM
3400026	U	3/21/2011	L1	3/21/2011	17	14	8	10	5/24/2011	7		8		✓		3/31/2011		6/7/2011 11:00AM
3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓		5/31/2011		6/14/2011 11:00AM
3400013	U	12/28/2010	L1	12/27/2010	19	15	9	22	5/17/2011	3		4		✓	4/19/2011	1/20/2011		6/14/2011 5:00PM
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3400015	U	1/18/2011	L1	1/18/2011	17	4	11	19	5/25/2011	4*		5*		✓		1/24/2011		6/1/2011 4:30PM
3400028	U	4/19/2011	L1	4/19/2011	14	14	4	6	5/31/2011	9*		10*		✓		5/23/2011		6/7/2011 10:00AM
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3400029	U	5/2/2011	L1	5/2/2011	24	16	3	4	5/24/2011	7		5		✓		5/16/2011		6/6/2011 8:30AM

1 - 24 of 24 — Per page: 200

Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1↑: Patient has been graduated from L2.
L2≠: Patient is still not taken by a Case Manager after 14 days.
Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10
Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

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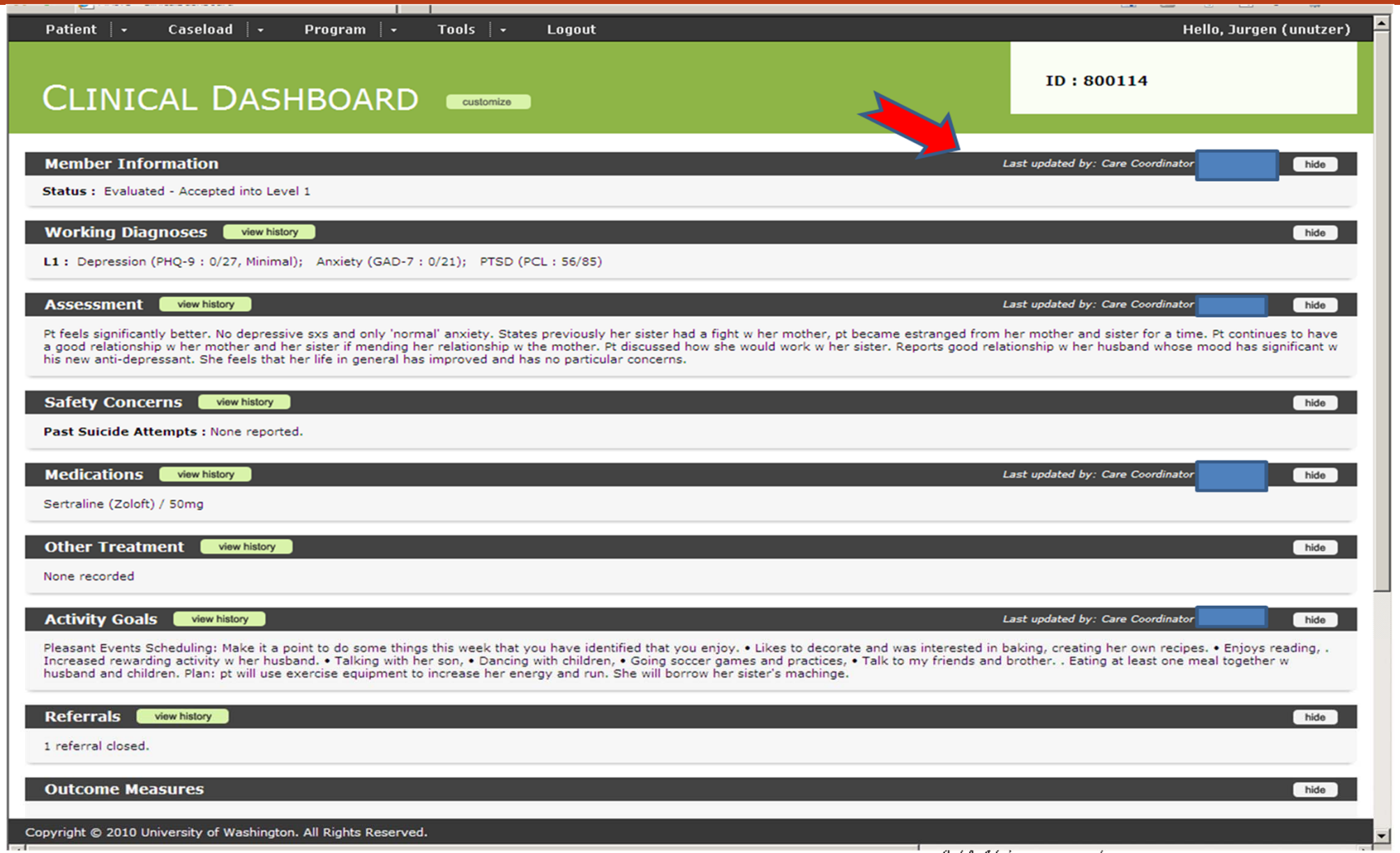
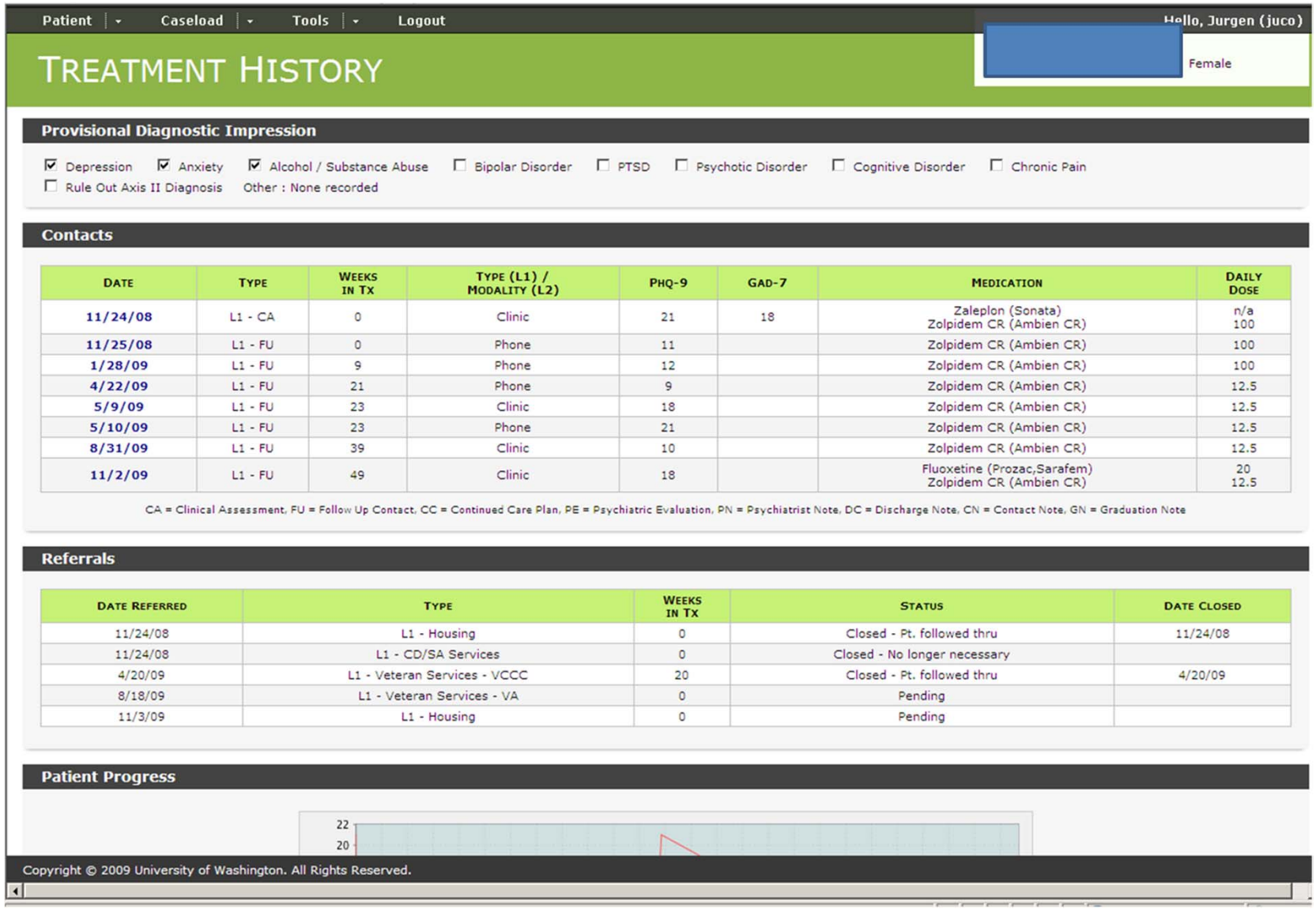
Internet 100% — Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... 1:54 PM

Clinical Dashboard: Shared Patient Summary



Summary of Treatment History



Patient | Caseload | Tools | Logout

Hello, Jurgen (juco)

TREATMENT HISTORY

[redacted]

Female

Provisional Diagnostic Impression

☑ Depression ☑ Anxiety ☑ Alcohol / Substance Abuse ☐ Bipolar Disorder ☐ PTSD ☐ Psychotic Disorder ☐ Cognitive Disorder ☐ Chronic Pain

☐ Rule Out Axis II Diagnosis Other : None recorded

Contacts

DATE	TYPE	WEEKS IN TX	TYPE (L1) / MODALITY (L2)	PHQ-9	GAD-7	MEDICATION	DAILY DOSE
11/24/08	L1 - CA	0	Clinic	21	18	Zaleplon (Sonata) Zolpidem CR (Ambien CR)	n/a 100
11/25/08	L1 - FU	0	Phone	11		Zolpidem CR (Ambien CR)	100
1/28/09	L1 - FU	9	Phone	12		Zolpidem CR (Ambien CR)	100
4/22/09	L1 - FU	21	Phone	9		Zolpidem CR (Ambien CR)	12.5
5/9/09	L1 - FU	23	Clinic	18		Zolpidem CR (Ambien CR)	12.5
5/10/09	L1 - FU	23	Phone	21		Zolpidem CR (Ambien CR)	12.5
8/31/09	L1 - FU	39	Clinic	10		Zolpidem CR (Ambien CR)	12.5
11/2/09	L1 - FU	49	Clinic	18		Fluoxetine (Prozac,Sarafem) Zolpidem CR (Ambien CR)	20 12.5

CA = Clinical Assessment, FU = Follow Up Contact, CC = Continued Care Plan, PE = Psychiatric Evaluation, PN = Psychiatrist Note, DC = Discharge Note, CN = Contact Note, GN = Graduation Note

Referrals

DATE REFERRED	TYPE	WEEKS IN TX	STATUS	DATE CLOSED
11/24/08	L1 - Housing	0	Closed - Pt. followed thru	11/24/08
11/24/08	L1 - CD/SA Services	0	Closed - No longer necessary	
4/20/09	L1 - Veteran Services - VCCC	20	Closed - Pt. followed thru	4/20/09
8/18/09	L1 - Veteran Services - VA	0	Pending	
11/3/09	L1 - Housing	0	Pending	

Patient Progress

22
20

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Principles of Integrated Behavioral Health Care

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- Treatments used are ‘evidence-based’.

Screening Tools as "Vital Signs"

Behavioral health screeners are like monitoring blood pressure!

- **Identify that there is a problem**
- **Need further assessment to understand the cause of the "abnormality"**
- **Help with ongoing monitoring to measure response to treatment**

Commonly Used Screeners

Mood Disorders

- PHQ-9: Depression
- MDQ: Bipolar disorder
- CIDI: Bipolar disorder

Anxiety Disorders

- GAD- 7: Anxiety, GAD
- PCL-C: PTSD
- OCD: Young-Brown
- Social Phobia: Mini social phobia

Psychotic Disorders

- Brief Psychiatric Rating Scale
- Positive and Negative Syndrome Scale

Substance Use Disorders

- CAGE-AID
- AUDIT

Cognitive Disorders

- Mini-Cog
- Montreal Cognitive Assessment

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE: _____

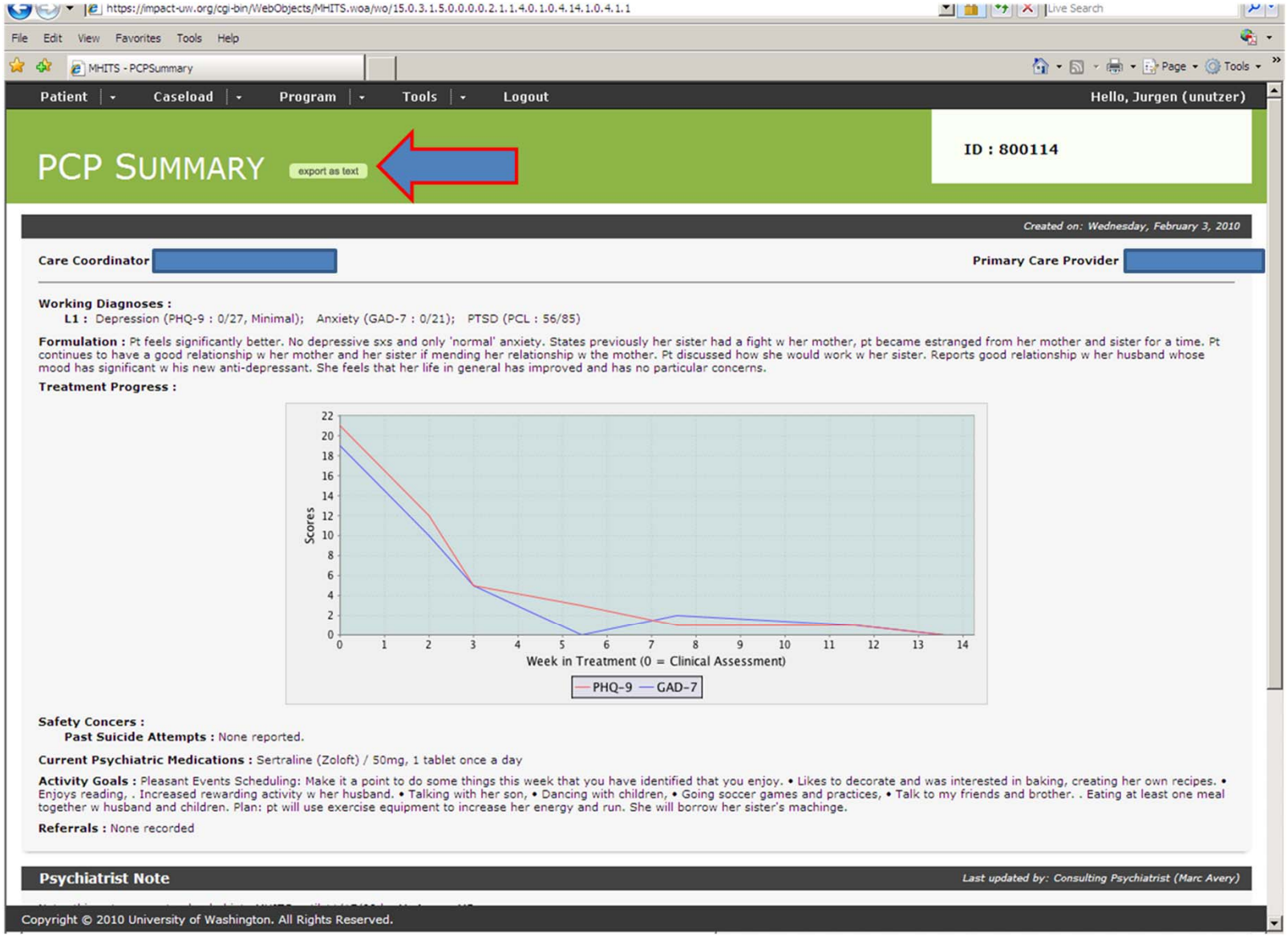
Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **TOTAL:**			15	

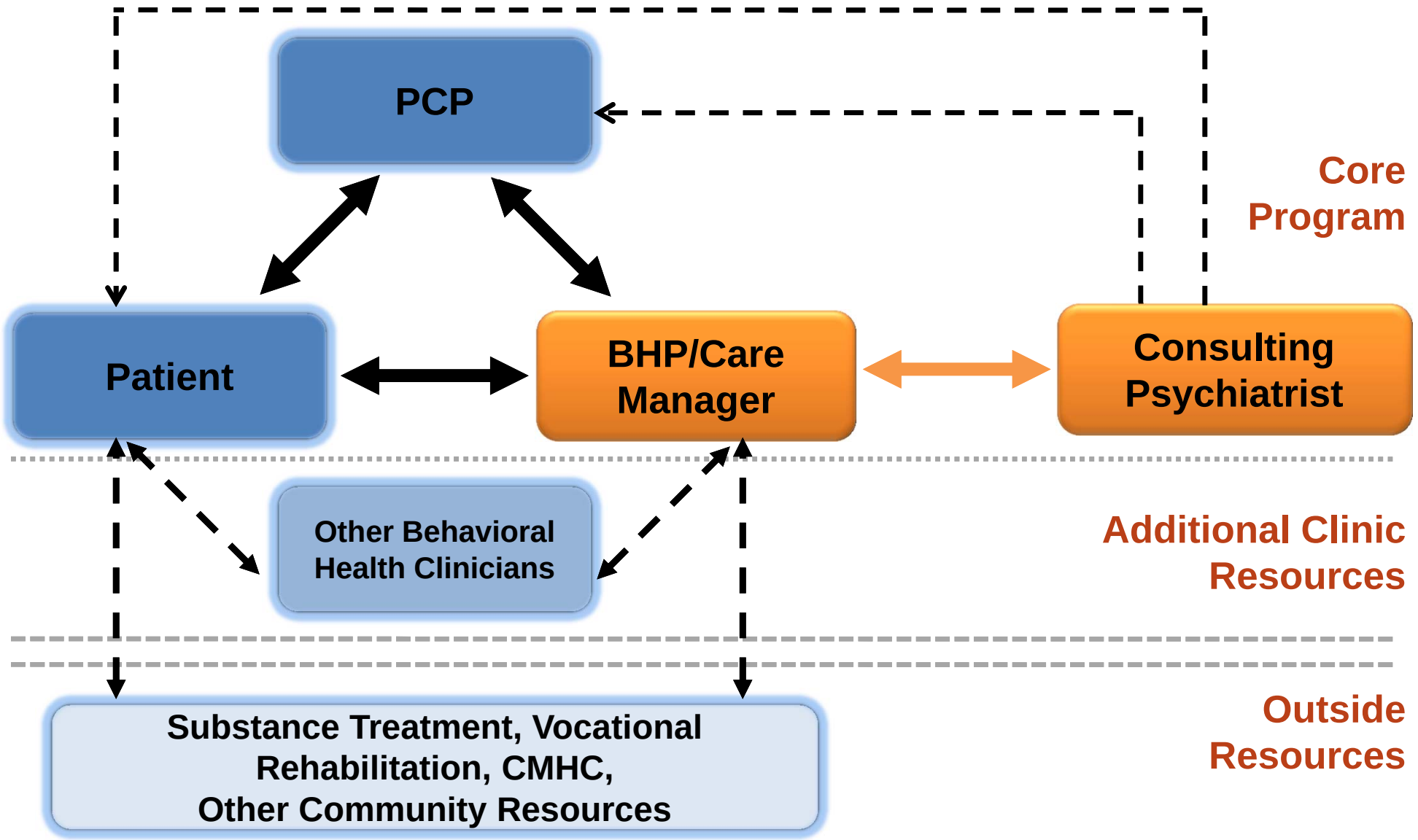
10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult ✓
- Very difficult _____
- Extremely difficult _____

Track Treatment Outcome Over Time



Collaborative Team Approach



Working with BHPs/Care Managers

Who are the BHPs/CMs?

- Typically MSW, LCSW, MA, RN, PhD, PsyD
- Variable clinical experience

What makes a good BHP/CM?

- Organization
- Persistence
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

BHP/Care Manager Toolkit

Clinical Skills

- Basic assessment skills
- Use of common screening tools
- Concise, organized presentations

Behavioral Medicine & Brief Psychotherapy

- Motivational interviewing
- Distress tolerance skills
- Behavioral activation
- Problem solving therapy
- → More in Module 4

Other Skills

- Referrals to other behavioral health providers and community Resources
- Excellent communication skills

Caseload Consultation vs Caseload Supervision

Caseload Consultation

-Discuss overall caseload

-Specific case reviews

- Diagnostic clarification
- Treatment planning
- Medication recommendation

Caseload Supervision

- Discuss reactions to patients
- May involve specific therapy planning

Tips for Working with BHPs/Care Managers

Ask about training

- Helpful to know training background and experience of BHP/CM
- What is in their tool kit? → See more in Module 4

Assess for Strengths

- Ability to give concise, organized patient presentations
- Utilize strong skills to aid in patient care (eg if BHP/CM trained in specific therapy modality suggest appropriate application of this skill)

Understand Limitations

- Can you trust their assessments?
- Lack of training in a certain area will be an opportunity to provide education

Monitor for 'Burnout'

- Weekly/frequent consultation allows for early identification of caregiver fatigue

Communication with BHPs/Care Managers

Method of Consultation

- Electronic communication (e-mail, instant messaging, cell phone text)
- In person
- Tele-video
- Telephone

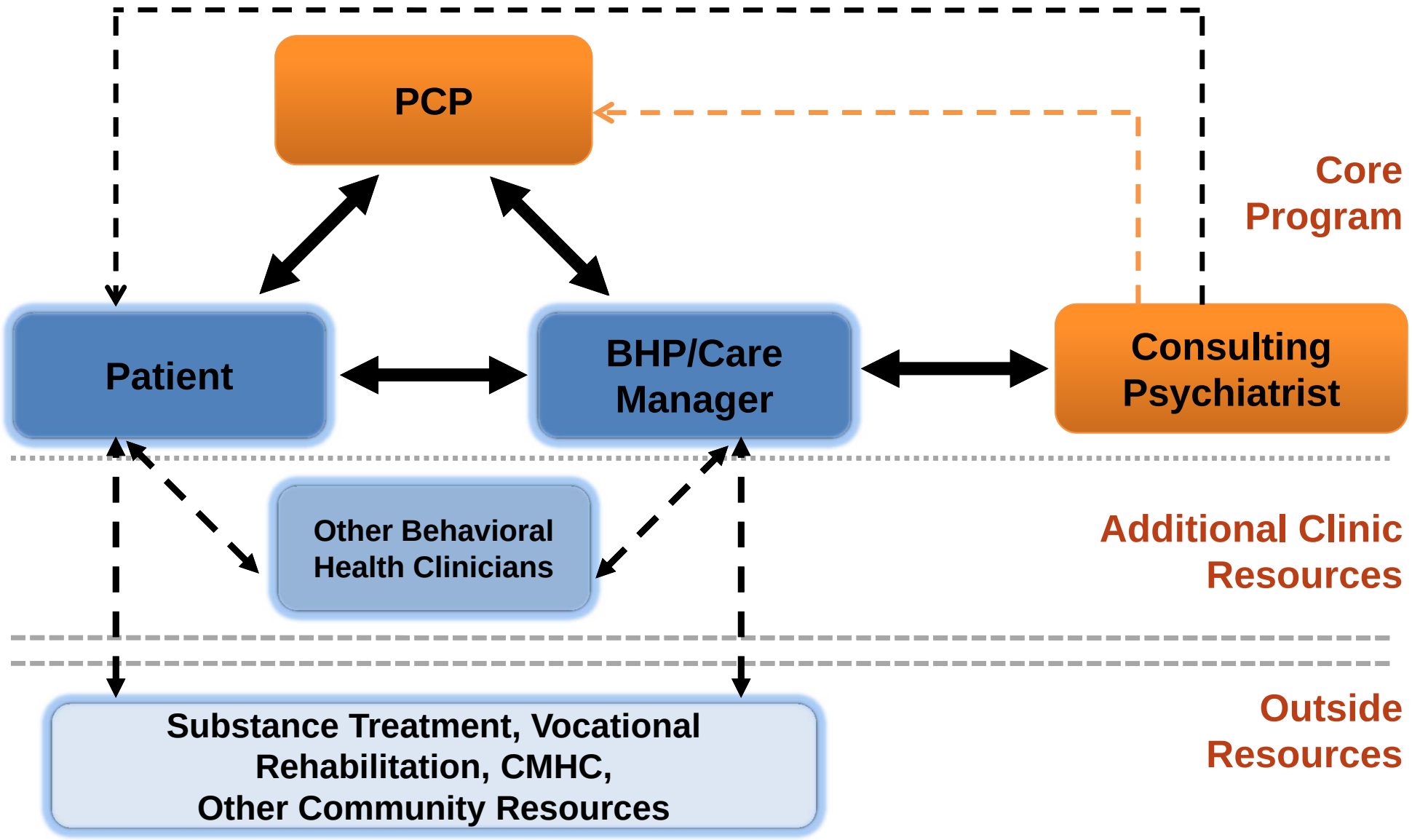
Consultation Schedule

- Regularly scheduled
- Frequency

Integrating Education

- Integrate education into consultations whenever possible.
- Scheduled trainings (CME, Brown Bag lunch, etc).
- Journal articles, handouts, protocols, etc (either in person or electronically).
- Encourage BHPs to attend educational meetings with me

Collaborative Team Approach



Your Offer

“I’m here for you.”

“I’ve got your back."

Tips for Working with PCPs

Availability and Accessibility

- Easy access for PCP
  - Same day for curbside questions
  - Typically by pager, e-mail, cell phone
- Not utilized as much as would expect!

Selling integrated care → See More in Module 2

- Expect questions and possible skepticism / resistance
- Promote yourself as a resource
- Resist 'regression to co-location'
- Teach the model
  - BHP/Care manager will assess patient first
  - New role to support the BHP/Care manager and support team treatment

Communication with PCPs

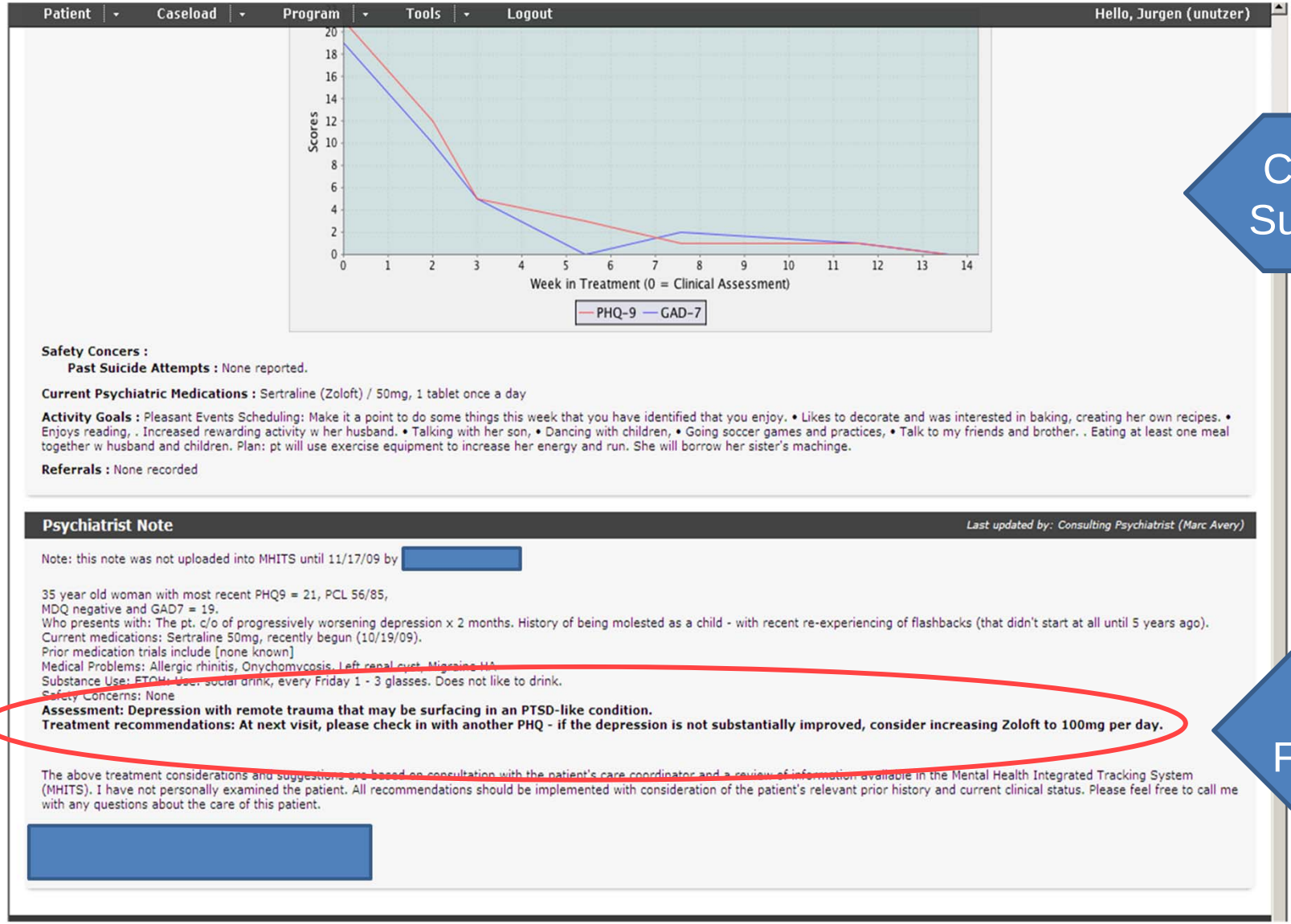
Recommendations

- Brief and focused
- Next steps for assessment and diagnostic clarification
- Treatment: Both medication recommendations and behavioral interventions

Provide Education

- Through patient-focused recommendations
- Webinar or in person at provider meetings

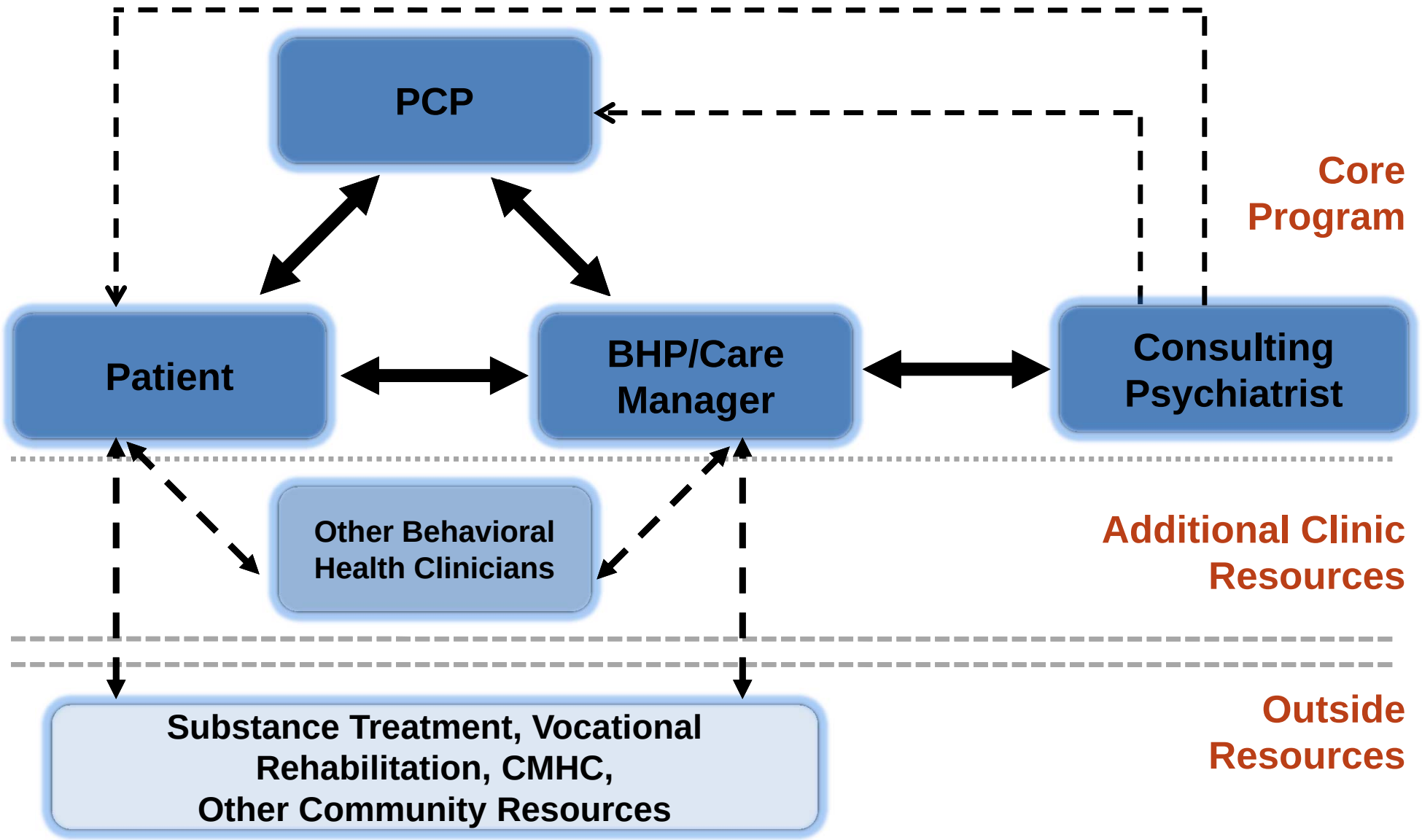
Example: Psychiatric Recommendations



Concise Summary

Brief & Focused

Collaborative Team Approach



Assessment and Diagnosis in the Primary Care Clinic

Functioning as a “back seat driver”

- Develop an understanding of the relative strengths and limitations of the providers on your team
- Relying on other providers (PCP and BHP/Care Manager) to gather history

How do you “steer”?

- Structure your information gathering
- Include assessment of functional impairment
- Pay attention to mental status exam

Example: Structured Assessment

BHP/Care Manager is asked to briefly report on each of the following areas:

- Depressive symptoms
- Bipolar Screen
- Anxiety symptoms
- Psychotic symptoms
- Substance use
- Other (Cognitive, Eating Disorder, Personality traits):
- Past Treatment
- Safety/Suicidality
- Psychosocial factors
- Medical Problems
- Current medications
- Functional Impairments
- Goals

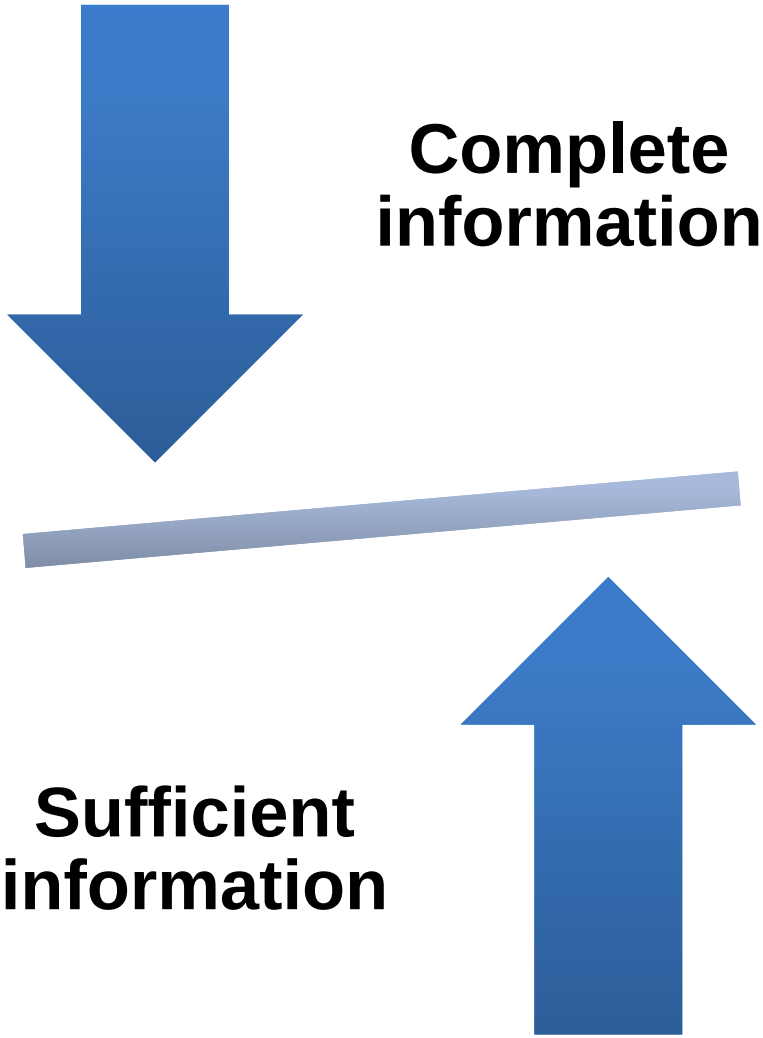
A Different Kind of Assessment: Shaping Over Time

Traditional Consult

One Session

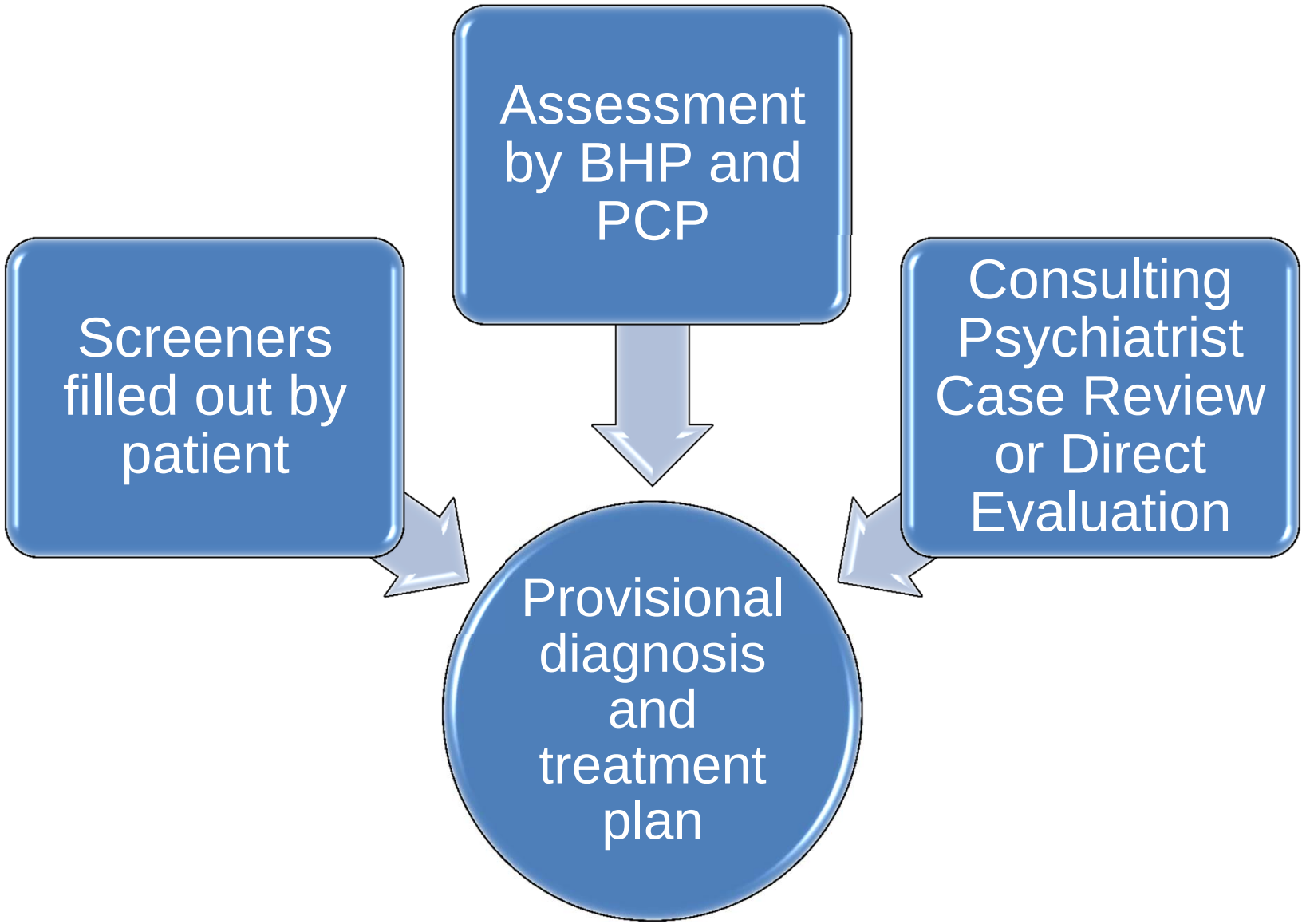
Integrated Care Consult

Uncertainty: Requests for More Information

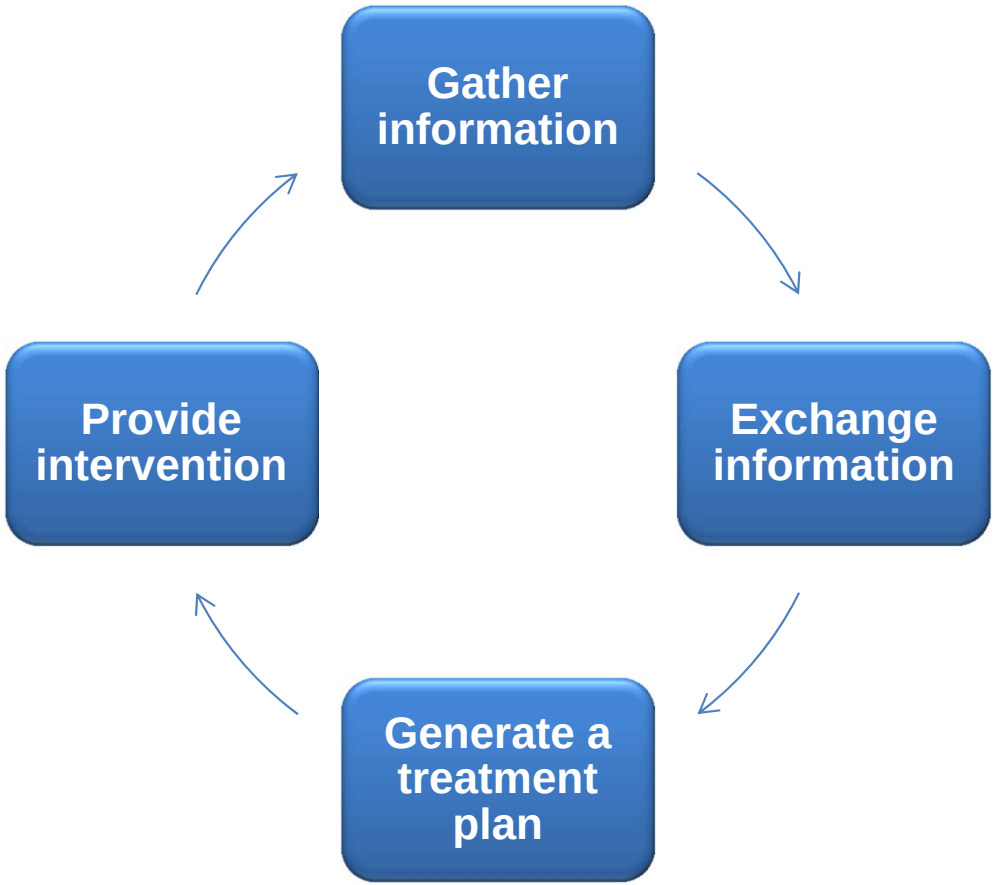


- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing

Provisional Diagnosis



Assessment and Diagnosis in the Primary Care Clinic



-Diagnosis can require multiple iterations of assessment and intervention

-Advantage of population based care is longitudinal observation and objective data

-Start with diagnosis that is your ‘best understanding’

Common Consultation Questions

Clarification of diagnosis

- Consider re-screening patient
- Patient may need additional assessment

Address treatment resistant disorders

- Make sure patient has adequate dose for adequate duration
- Provide multiple additional treatment options

Recommendations for managing difficult patients

- Help differentiate crisis from distress
- Support development of treatment plans/team approach for patients with behavioral dyscontrol
- Support protocols to meet demands for opioids, benzodiazepines etc…
- Support the providers managing THEIR distress

Caseload Consultation

If patients do not improve, consider

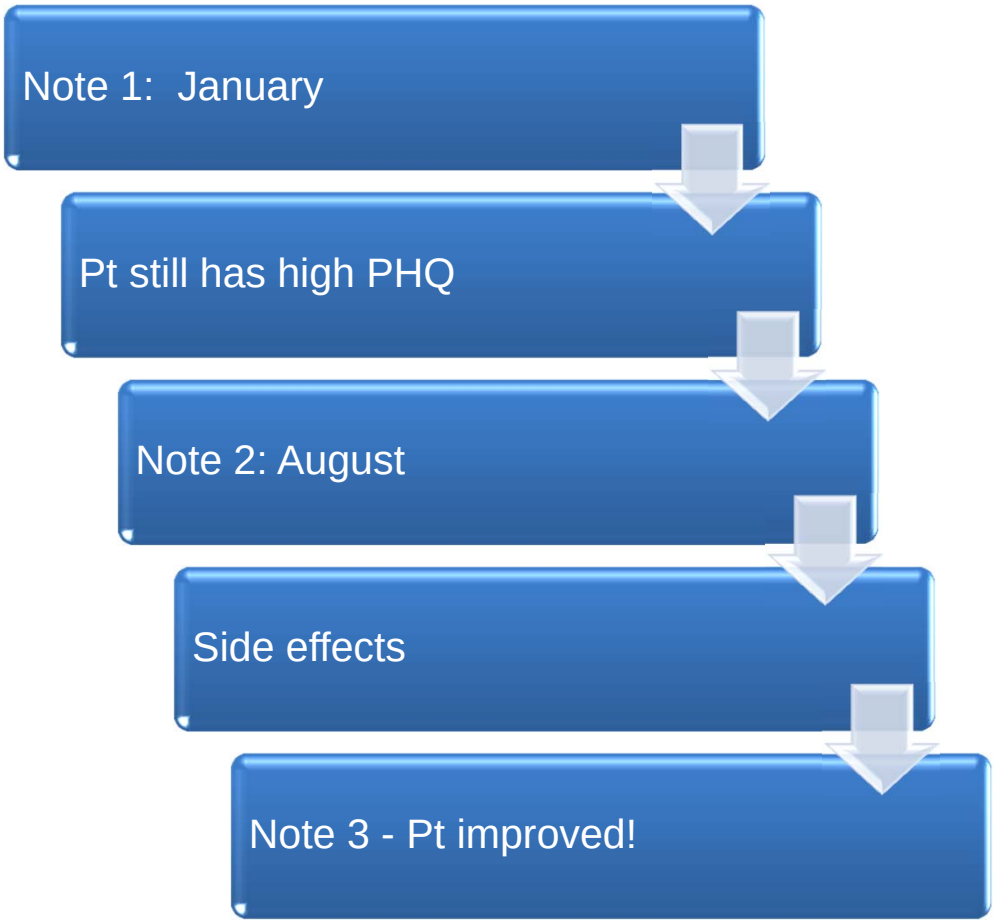
- Wrong diagnosis?
- Problems with treatment adherence?
- Insufficient dose / duration of treatment?
- Side effects?
- Other complicating factors?
  - psychosocial stressors / barriers
  - medical problems / medications
  - ‘psychological’ barriers
  - substance abuse
  - other psychiatric problems
- Initial treatment not effective?

A Different Kind of Note

Traditional Consult Note

One consult note

Integrated Care Consult Note



Example: ‘Disclaimer’ on Consultation Note

“The above treatment considerations and suggestions are based on consultations with the patient’s care manager and a review of information available in the Mental Health Integrated Tracking System (MHITS). I have not personally examined the patient. All recommendations should be implemented with consideration of the patient’s relevant prior history and current clinical status. Please feel free to call me with any questions abut the care of this patient. “

Dr. x, Consulting Psychiatrist

Phone #.

Pager #.

E-mail

Principles of Integrated Behavioral Health Care

Patient Centered Care

- Team-based care: effective collaboration between PCPs and Behavioral Health Providers.

Population-Based Care

- Behavioral health patients tracked in a registry: no one ‘falls through the cracks’.

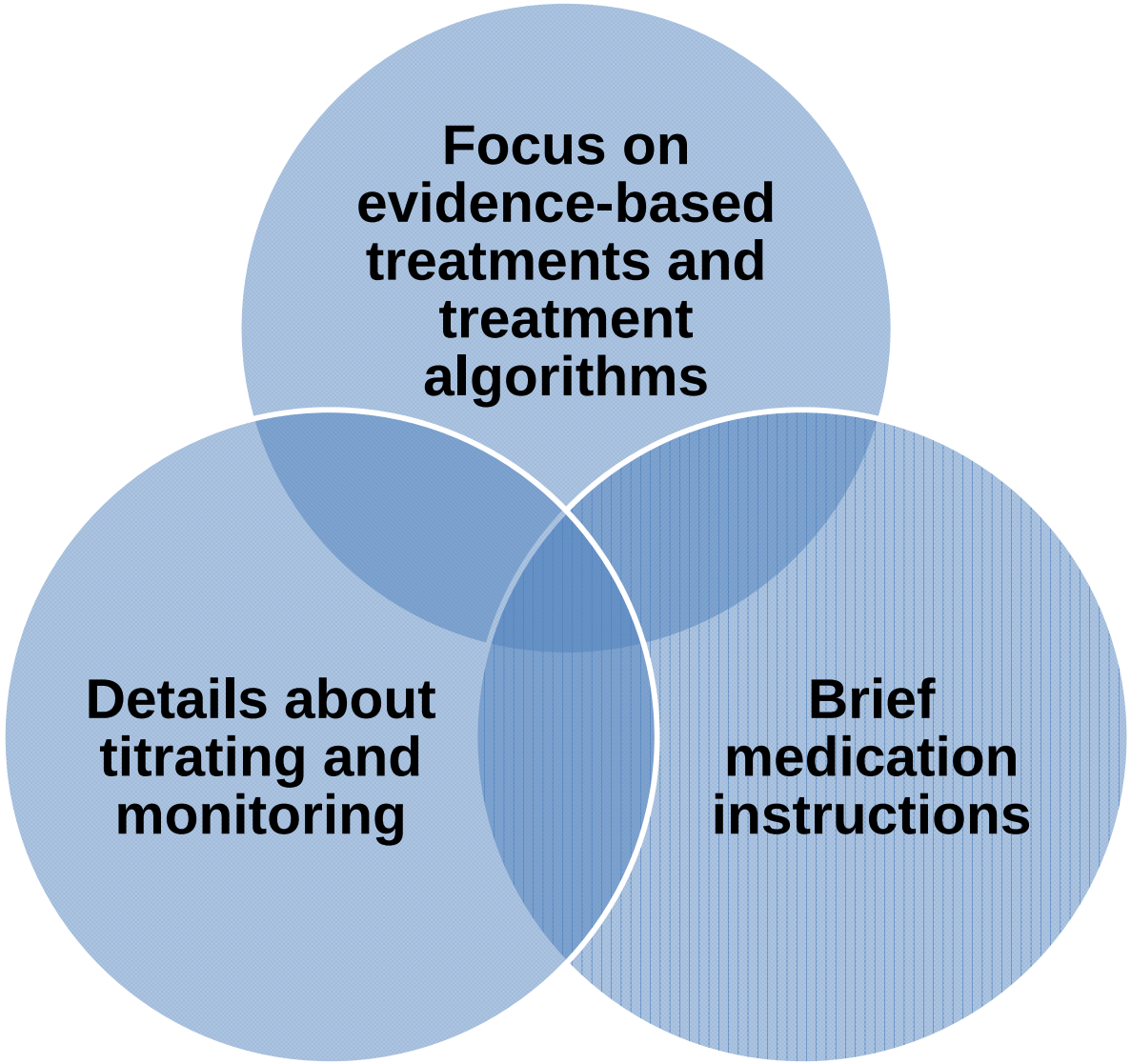
Measurement-Based Treatment to Target

- Measurable treatment goals and outcomes defined and tracked for each patient.
- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

- Treatments used are ‘evidence-based’.

Recommendations: Pharmacological Treatment



Example: Medication Recommendation for Lithium – Part 1

Name	• Lithium (Lithium Carbonate), Lithium-Controlled Release (Lithium ER, Lithobid)
Initiation - Week 1:	• Check baseline labs (urine pregnancy, basic metabolic panel (baseline BUN and Cr), CBC (for baseline WBC) TSH, consider EKG. • Start Lithium 300 mg BID or 600 mg QHS (may start with 300 mg/qhs, if the patient is less acute or sensitive to side effects).
Week 2 and Beyond:	• Check lithium level weekly and as indicated increase dose in 300 mg/day increments to target plasma level of 0.8-1.0 meq/L.
Typical Target:	• Plasma level 0.8-1.0 meq/L and less than 1.2 meq/L which usually equates with daily dose of 1200 mg to 1800 mg.
Dosing:	• Schedule should be determined by tolerability and compliance; Typically BID or QHS.

Example: Medication Recommendation for Lithium – Part 2

Monitoring:	• Lithium level 5-7 days after dose change (ideally 12 hours after last dose) and Q6 months when stable; Other labs: Baseline labs as above, Repeat at Q3 months X 2 and Q6 months
General Information:	• Natural salt with mood stabilizer efficacy.
FDA Indications:	• Bipolar disorder, mania; bipolar disorder, maintenance. Off-Label Indications: Bipolar disorder, depression; depression augmentation; anti-suicide effect.
Contraindications:	• Significant renal impairment, significant cardiovascular disease, psoriasis, sodium depletion, dehydration, debilitation.
Side effects: Common:	• Nausea, tremor, polyuria (related to nephrogenic diabetes insipidus) and thirst, weight gain, loose stools, cognitive impairment (sedation, including changes in memory, concentration, apathy, and decreased creativity).
Rare but serious:	• The two most important long-term adverse effects of lithium involve the kidneys and thyroid gland; In addition, cardiac rhythm disturbances have been described (these almost always occur in patients with preexisting cardiac disease).

Example: Medication Recommendation for Lithium – Part 3

Black Box Warning:	• Toxicity can occur at levels close to therapeutic dosing; Mild symptoms occur at 1.5-2.5 meq/L (increase tremor, slurred speech and increased lethargy), Moderate 2.5-3.5 meq/L (clonus, coarse tremors, worsening lethargy) and Severe above 3.5 meq/L which can be lethal
Pregnancy:	• Category D; Cardiac malformations, including Ebstein's anomaly (background rate of this defect is 1/20,000 births compared to the 1/1000 rate among infants exposed to lithium in utero—need to inform women of childbearing age of this risk), are the primary risk of using lithium during the first trimester.
Breastfeeding:	• American Academy of Pediatrics Committee on Drugs has classified lithium as "incompatible" with breastfeeding, due to documented accumulations in both maternal breast milk and infant serum.
Significant drug-drug interactions:	• Check all drug-drug interactions before prescribing. Examples include thiazide diuretics, NSAIDS (except aspirin), ACE-inhibitors, tetracyclines, metronidazole, potassium-sparing diuretics, theophylline, loop diuretics, calcium channel blockers.
Generic available:	• Yes, and inexpensive.

Recommendations: Other Interventions

Support managing difficult patients

- Working with demanding patients
- Protocols for managing suicidal ideation
- Working with patients with chronic pain →Module 5

More recommendations "Beyond Medications"

- → Module 4
  - Behavioral Medicine and Brief Psychotherapy
  - Referrals and Community Resources
  - Disability

Recommendations: Example for Psychiatric Crises

Suicidal ideation is common

- Suicide was the 11th leading cause of death in the United States in 2000
- Most patients who commit suicide have seen a PCP in past month

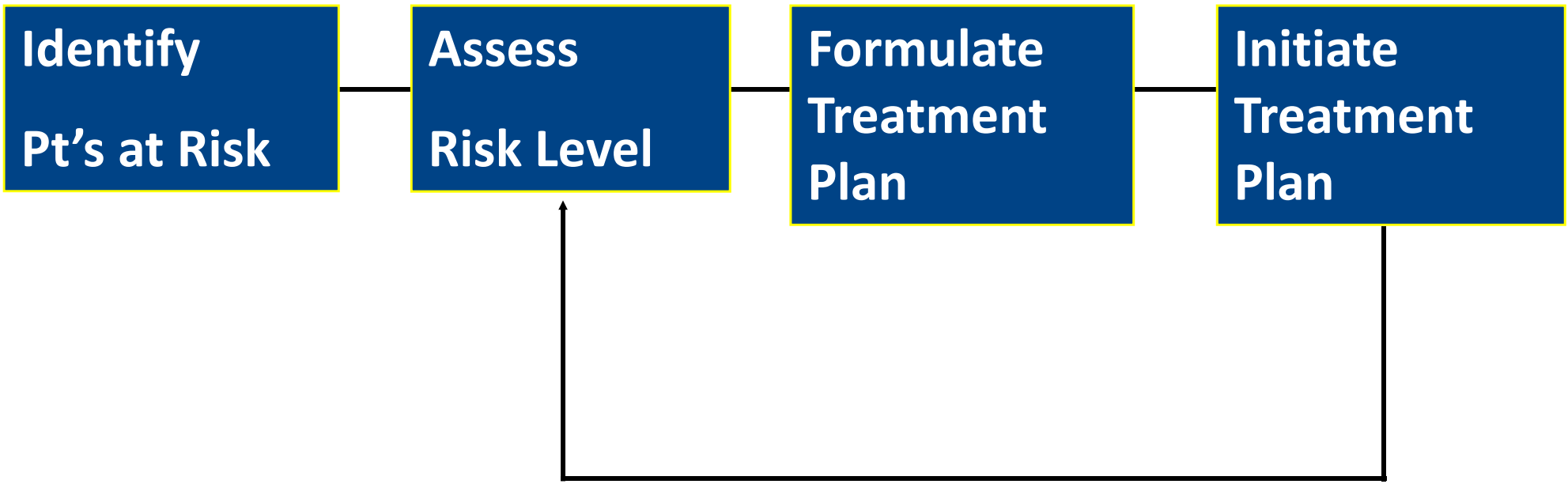
Assessing suicidal ideation

- BHP/CM and PCP need to review screeners especially Question 9 on the PHQ-9
- Enhance ability to differentiate active SI from passive SI

Not the first line provider

- Support clinics to develop a crisis protocol including clinic plan and local resources for suicidal ideation, homicidal ideation and grave disability

Recommendations: Example Suicide Risk Management



Recommendations:
Example Establishing a Clinical Protocol

If your clinic does not currently have a protocol for dealing with suicidal patients, that is the first step.

Elements of a protocol:

- **What is done immediately with patient?**
- **Who is consulted?**
- **What does follow-up look like?**

Recommendations: Example Working with Difficult Patients

Coaching PCP Skills:

How to say no to a demanding patient.

Set your goals

- Recognize your own values and triggers
- Consider using a preplanned strategy for situations that you encounter often, i.e. narcotics/unnecessary tests

Explore patient's goals/concerns

- "How had you hoped I could help you with this?"
- Try to find underlying concerns
- This may change a rant into a conversation

Try Disarming Statements

- Actively helps pt make their point and calm down
- "I see your point,"
- "I understand," "I agree"
- "You're right, you did have to wait a long time"

Model calmness.

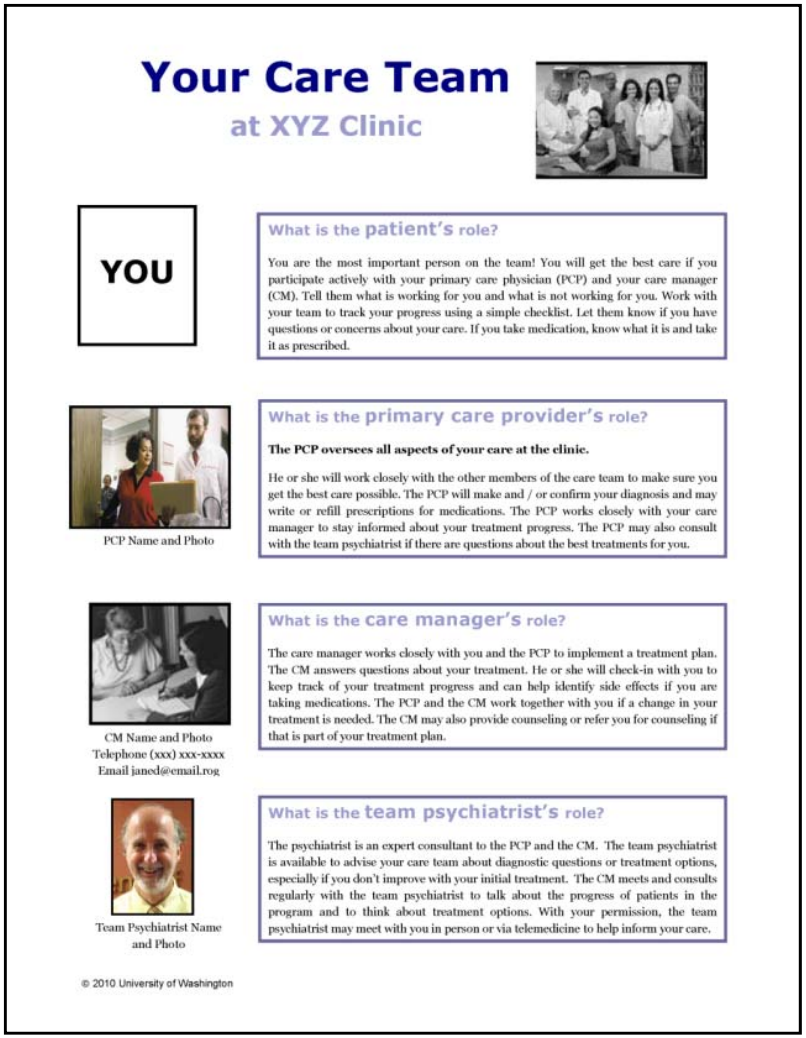
- Lower your voice, move so they must turn in your direction
- Encourage them to sit down--but let them control where to sit

Working Together to Sell a Treatment Plan

ONE treatment plan!

- Regular communication
- All members of the team give consistent recommendations
- Consider “team huddles”
- Share appointments

Your Care Team



Your Care Team
at XYZ Clinic

YOU

What is the patient's role?

You are the most important person on the team! You will get the best care if you participate actively with your primary care physician (PCP) and your care manager (CM). Tell them what is working for you and what is not working for you. Work with your team to track your progress using a simple checklist. Let them know if you have questions or concerns about your care. If you take medication, know what it is and take it as prescribed.

PCP Name and Photo

What is the primary care provider's role?

The PCP oversees all aspects of your care at the clinic.

He or she will work closely with the other members of the care team to make sure you get the best care possible. The PCP will make and / or confirm your diagnosis and may write or refill prescriptions for medications. The PCP works closely with your care manager to stay informed about your treatment progress. The PCP may also consult with the team psychiatrist if there are questions about the best treatments for you.

CM Name and Photo
Telephone (xxx) xxx-xxxx
Email janed@email.rog

What is the care manager's role?

The care manager works closely with you and the PCP to implement a treatment plan. The CM answers questions about your treatment. He or she will check-in with you to keep track of your treatment progress and can help identify side effects if you are taking medications. The PCP and the CM work together with you if a change in your treatment is needed. The CM may also provide counseling or refer you for counseling if that is part of your treatment plan.

Team Psychiatrist Name and Photo

What is the team psychiatrist's role?

The psychiatrist is an expert consultant to the PCP and the CM. The team psychiatrist is available to advise your care team about diagnostic questions or treatment options, especially if you don't improve with your initial treatment. The CM meets and consults regularly with the team psychiatrist to talk about the progress of patients in the program and to think about treatment options. With your permission, the team psychiatrist may meet with you in person or via telemedicine to help inform your care.

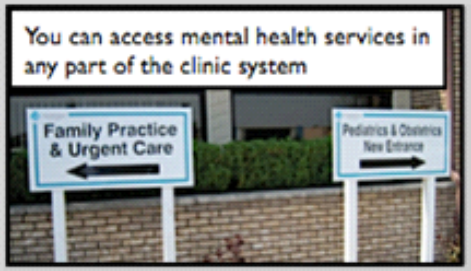
A Sample Program

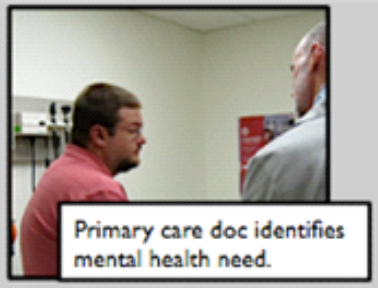
John Kern, MD

Sample Program: Initial Model of Care – March 2008

- "Emergency Intake" style of initial evaluation.
- Premium on immediate availability to primary care provider.
- Frequent psychiatrist phone consultation.
- No routine patient contact with psychiatrist.
- Use of toolkit, brief documentation [paper], rating scales.

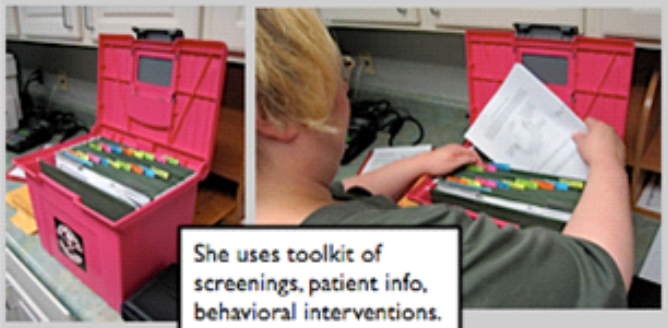
You can access mental health services in any part of the clinic system



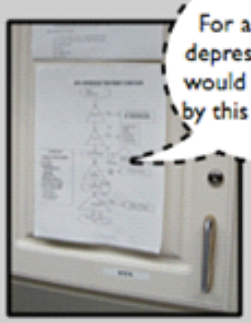


Primary care doc identifies mental health need.

Hand off to BHC for immediate consult.



She uses toolkit of screenings, patient info, behavioral interventions.



For a routine depression - we would prescribe by this protocol.

Hmm.. maybe bipolar. I'll call the psychiatrist for a consult.

He concurs - gives treatment suggestions.

Reporting findings to primary care doc

We often recommend behavioral activation.

eliciting support from family & others...

...and starting treatment with no other referral needed!

Sample Program: Evolution of Model of Care

- More return visits – IMPACT model.
- Medication focused, though this not intended.
- Primary care providers' communication with psychiatrist nearly always through BHC.
- Focus on family practice, fewer referrals from OB/GYN and pediatrics.
- Development of protocols for depression, then bipolar and ADHD.
- Role of depression registry.

Sample Program: Staffing

How many providers can be supported by 5-hr psychiatric consultant?

- Peds - 3 FTE
- OB/Gyn - 3.6 FTE
- Midwives - 2.5 FTE
- Family Practice – 6.7 FTE

→ Total: 15.8

But almost all the business is from the FP's !

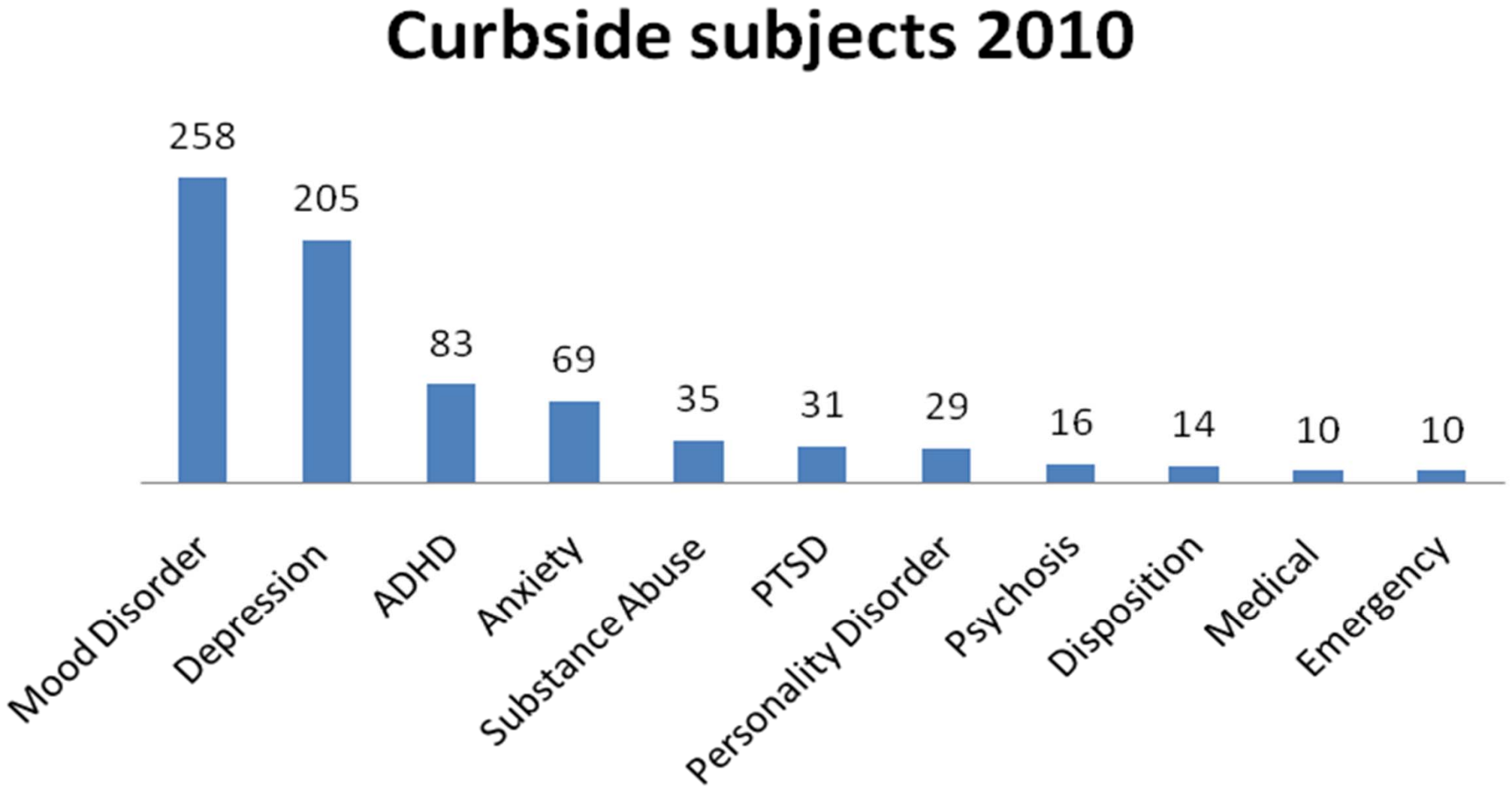
Sample Program: Psychiatrist Consultation

- 4 hours per week scheduled.
- Almost all by phone or text.
- “Rounds” one afternoon per week.
- Initially documented on palm pilot.
- Some personal contact essential →creates credibility with docs.

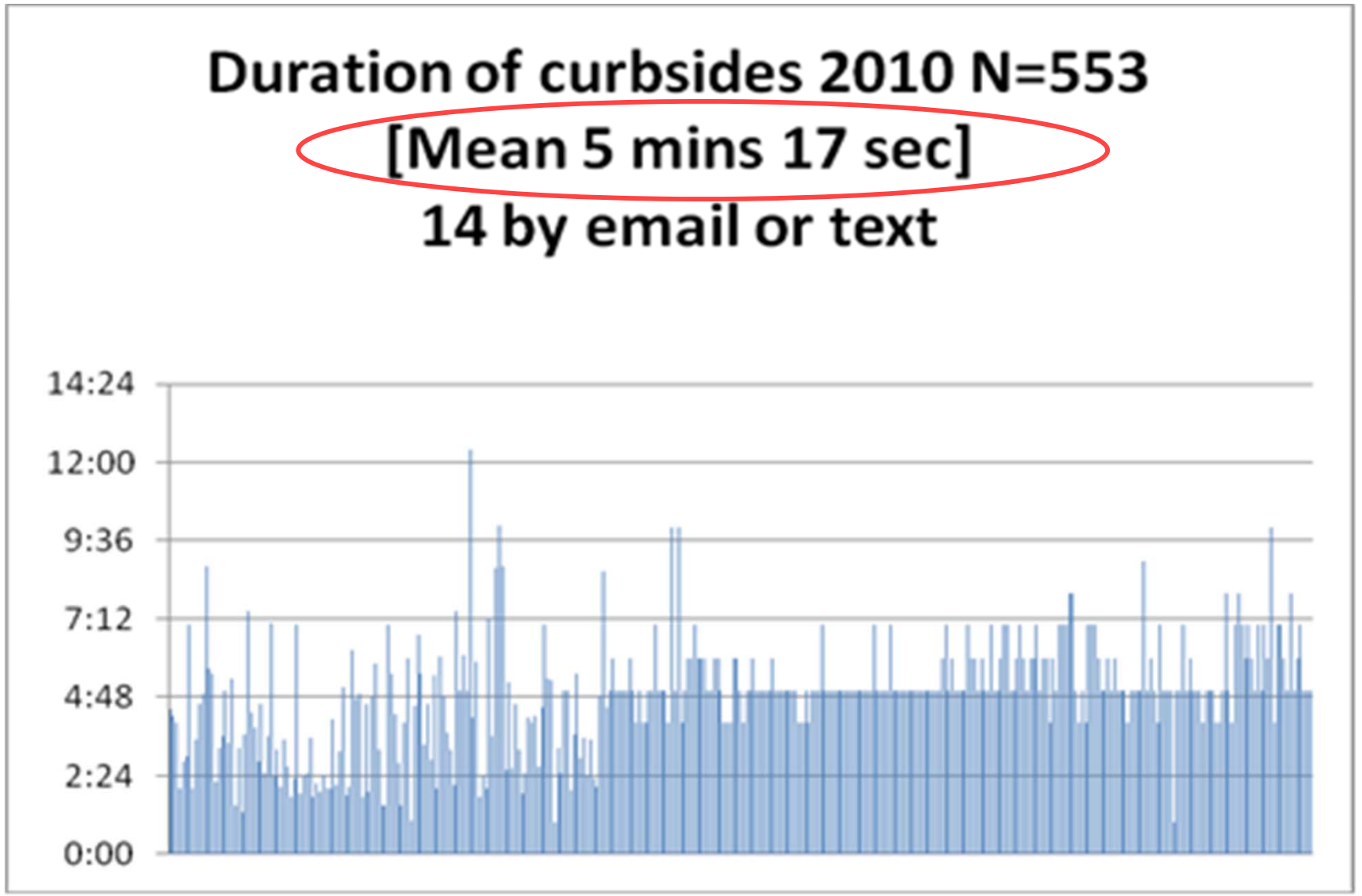
Sample Program: "Curbside" by Phone

- 70 per month or about 3.5 per day
  - 5.1 minutes per consult: about 15 mins per day.
- Subject – almost all diagnosis, disposition or psychopharmacology
- About 20% of cases lead to phone consult.

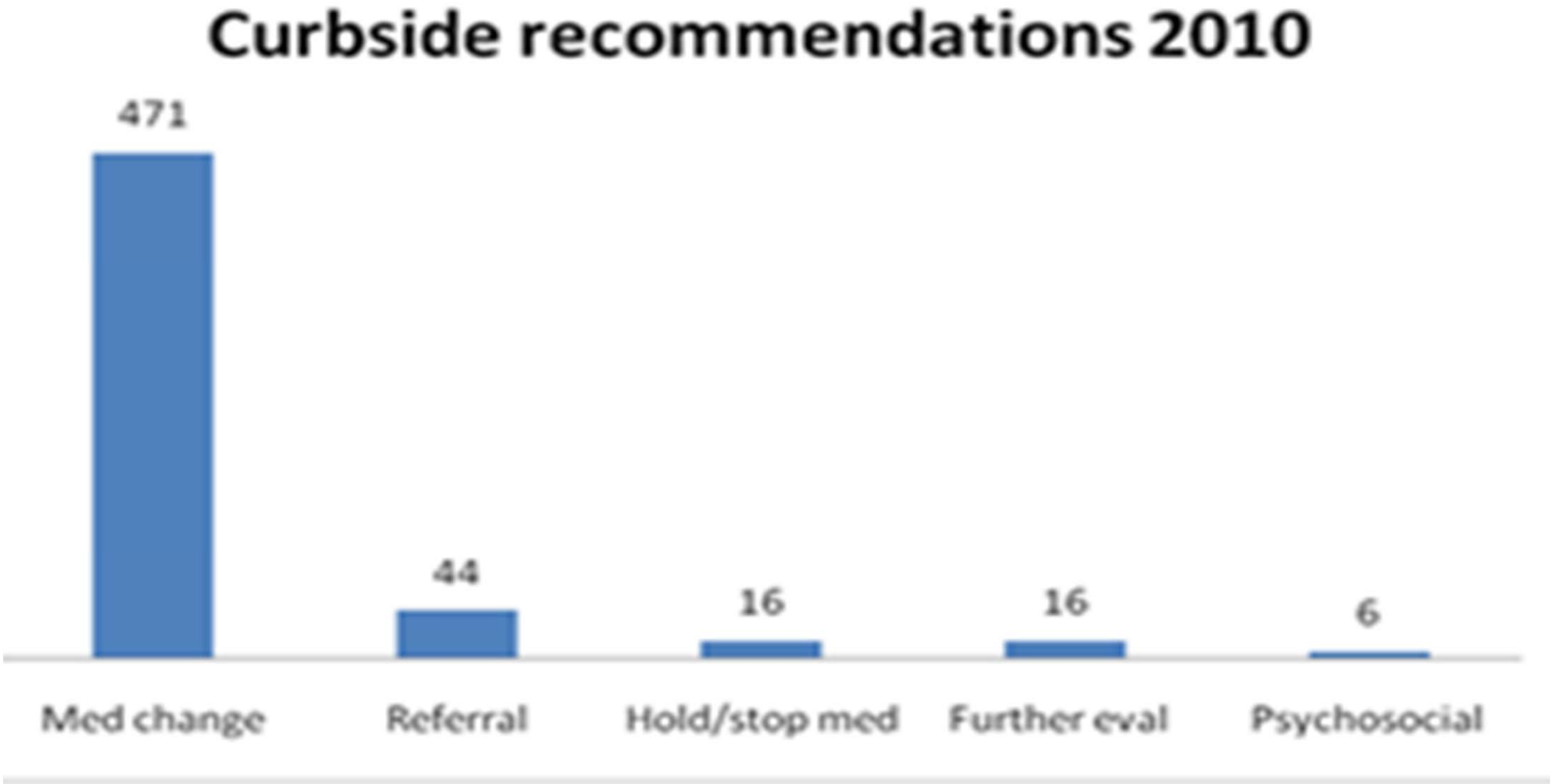
Sample Program: Consultation Subjects



Sample Program: Curbside Consultation Duration



Sample Program: Recommendation Topics



Sample Program: Supporting Behavioral Interventions

- I have to continually redirect BHC's to use non-med interventions, even they are experienced with using them – there is continual pressure from patients for "the magic pill"
- I also encourage them to keep track of this in the curbside database we keep, but they don't always do that, either.

Is integrated care psychiatric consulting for me?

Triage patients from variety of presentations	Develop new skills as an effective “back seat driver”	Support clinic development of skills
Working with PCPs	Working with BHCs	A different type of practice

Reflection Question: Is this for me?

Common attributes of the successful consulting psychiatrist:

- Flexible
- Adaptable
- Self-confident
- Outgoing
- Can appreciate the cadence of a primary care setting
- Willing to tolerate interruptions
- Likes to work in teams
- Can tolerate uncertainty
- Willing to consult on broad scope of patients
- Like doing something 'more than med checks'!

Reflection Questions

Reflective Thinking

- How will my I adapt my practice to a primary care setting? What will be challenging for me about adapting my practice to a primary care setting?
- What are my strengths in working in a team? What will be challenging for me about working in a team?
- Are there specific topics related to primary care psychiatry that I need to learn more about?

Adapt to Practice (including team building)

- Define the structure of your consultation to BHPs/Care Managers
- Map the work flow for communicating information from consultations to your PCPs
- Identify any areas and resources for information to enhance your knowledge
- Tailor treatment protocols to your practice setting

References

1) Katon, W., & Unutzer, J. (2011). Consultation psychiatry in the medical home and accountable care organizations: achieving the triple aim. *Gen Hosp Psychiatry, 33*(4), 305-310. doi: 10.1016/j.genhosppsych.2011.05.011

2) Kroenke, K., & Mangelsdorff, A. D. (1989). Common symptoms in ambulatory care: incidence, evaluation, therapy, and outcome. *Am J Med, 86*(3), 262-266.