

# Primary Care Consultation Psychiatry

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Supported by funding from the Center for Integrated Health Solutions

*SAMHSA-HRSA*  
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[www.CenterforIntegratedHealthSolutions.org](http://www.CenterforIntegratedHealthSolutions.org)

# The SAMHSA/HRSA Center for Integrated Health Solutions

***Providing information, experts, and  
resources dedicated to behavioral  
health and primary care integration***

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University of Washington

# AIMS CENTER

Advancing Integrated Mental Health Solutions



**Building on 25 years of Research and Practice  
in Integrated Mental Health Care**

# Primary Care Consultation Psychiatry

This series of five 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 1: Introduction to Primary Care Consultation Psychiatry**

# Learning Objectives: Module 1

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

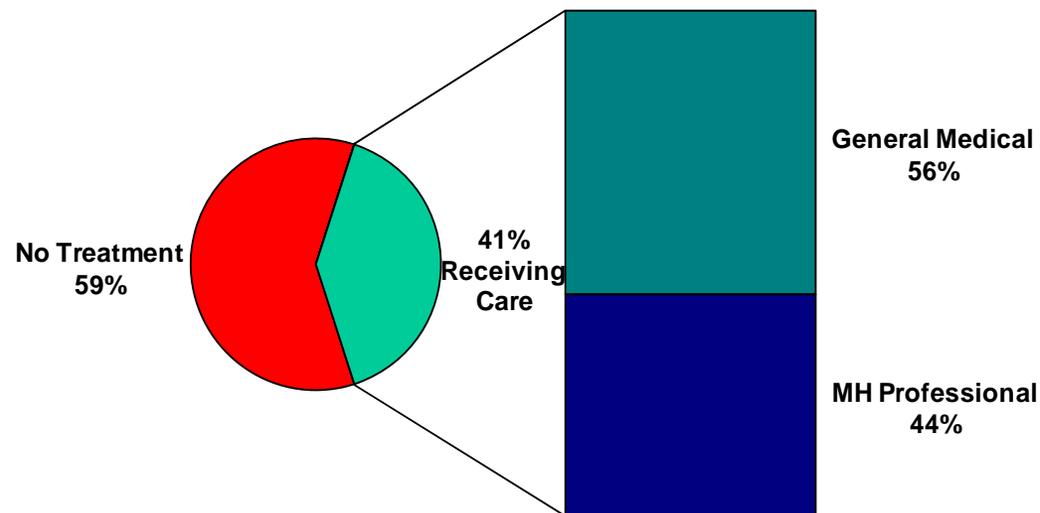
- **Make the case for integrated behavioral health services in primary care**
- **Discuss principles of and approaches to integrated behavioral health care**
- **List the evidence for collaborative care**
- **Describe roles for a primary care consulting psychiatrist in an integrated care team.**

# Why behavioral health care in primary care?

- 1. Access to care and reach:**  
Serve patients where they are
- 2. Patient-centered care:**  
Treat the ‘whole patient’
- 3. Effectiveness of care:**  
Make sure patients get better.

# Primary Care is the 'De Facto' Mental Health System

## National Comorbidity Survey Replication Provision of Behavioral Health Care: Setting of Service



Wang P, et al., Twelve-Month Use of Mental Health Services  
in the United States, Arch Gen Psychiatry, 62, June 2005

# BUT

- There is limited access to mental health specialists.

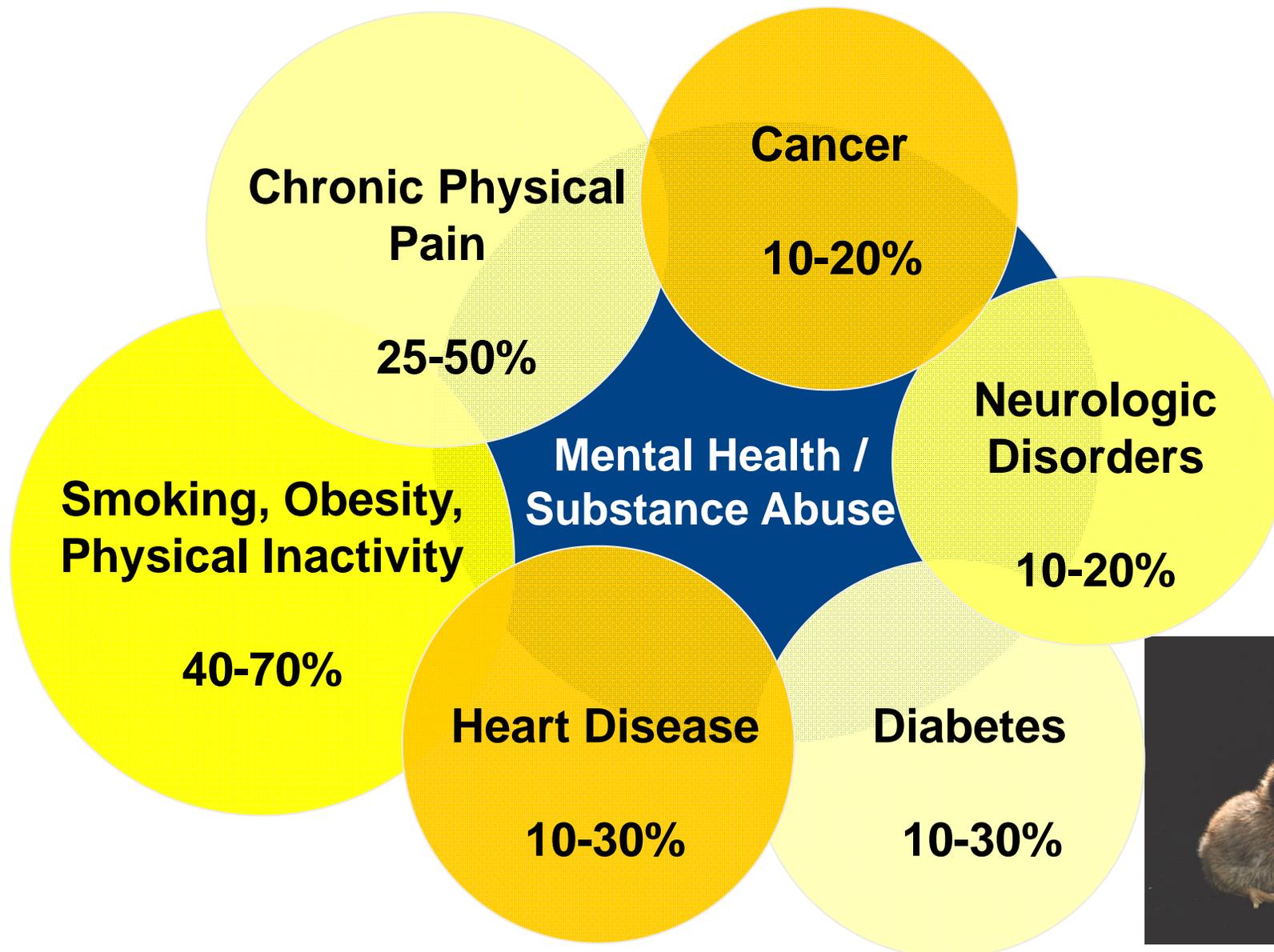
- 2/3 of PCPs report poor access to mental health care for their patients.



*"We couldn't get a psychiatrist, but perhaps you'd like to talk about your skin. Dr. Perry here is a dermatologist."*

Cunningham PJ, *Health Affairs* 2009;28(3)490-501

# Mental Disorders are Rarely the Only Health Problem



***Patient-centered care?***



# Bi-Directional Effects

25 yr mortality gap in seriously mentally ill

Behavioral Health

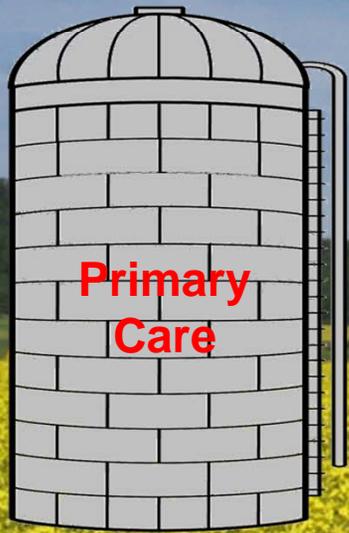
Physical Health

Depression =  
decreased medication  
adherence, smoking  
cessation, weight loss,  
or exercise

Patients with  
depression have  
higher health care  
costs

# Services are poorly coordinated.

*“Don’t you guys talk to each other?”*



# Only a minority of patients receive effective treatment.

~ 25% - 50 %

Not recognized or effectively engaged in care

~ 20 - 30 %

Drop out of treatment  
too early

~ 25 - 50 %

Stay on ineffective  
treatments for too long

# Health Care Reform:

## Moving towards coordinated / integrated care.

### Un-managed



**Fee  
for Service**

- **Fee For Service**
  - Inpatient focus
  - O/P clinic care
  - Low Reimbursement
  - Poor Access and Quality
  - Little oversight
- **No organized networks**
- **Focus on paying claims**
- **Little Medical Management**

### Coordinated Care



**Accountable  
Care**

- **Organized care delivery**
  - Aligned incentives
  - Linked by HIT
- **Integrated Provider Networks**
- **Focus on cost avoidance and quality performance**
  - **PC Medical Home**
  - **Care management**
  - **Transparent Performance Management**

### Patient Centered



**Integrated  
Health**

- **Patient Care Centered**
  - Personalized Health Care
  - Productive and informed interactions between Patient and Provider
  - Cost and Quality Transparency
  - Accessible Health Care Choices
  - Aligned Incentives for wellness
- **Multiple integrated network and community resources**
- **Aligned reimbursement/care management outcomes**
- **Rapid deployment of best practices**
- **Patient and provider interaction**
  - Information focus
  - Aligned self care management
  - E-health capable

# Integrated Behavioral Health Care: we are *'beyond the tipping point'*.

## A sampling of regional and national integrated behavioral health care initiatives:

- 25 years of NIMH Research on Collaborative Care [www.nimh.nih.gov](http://www.nimh.nih.gov)
- SAMHSA / HRSA Center for Integrated Health Solutions [www.CenterforIntegratedHealthSolutions.org](http://www.CenterforIntegratedHealthSolutions.org)
- John A. Hartford Foundation: IMPACT Program (<http://impact-uw.org>).
- MacArthur Initiative on Depression and Primary Care: RESPECT study and 3CM Model [www.depression-primarycare.org/](http://www.depression-primarycare.org/)
- HRSA Bureau of Primary Care Health Disparities Collaboratives (over 100 FQHCs) <http://www.hrsa.gov/mentalhealth/>
- RWJ Program: Depression in Primary Care—Linking Clinical and System Strategies
- NCCBH Collaborative Care Learning Collaboratives <http://www.thenationalcouncil.org/>
- California Endowment : Integrated Behavioral Health Project (IBPB) <http://www.ibhp.org/>
- CiMH <http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx>
- CAL MEND [www.calmend.org](http://www.calmend.org)
- Hogg Foundation for Mental Health Integrated Mental Health Initiative in Texas ([http://www.hogg.utexas.edu/programs\\_ihc.html](http://www.hogg.utexas.edu/programs_ihc.html))
- REACH-NOLA Project in New Orleans <http://reachnola.org/>
- VA, US Air Force, HMOs (Group Health, Kaiser Permanente), Cherokee, Washtenaw County (WCHO)
- Minnesota DIAMOND Program ([http://www.icsi.org/health\\_care\\_redesign/diamond\\_35953/](http://www.icsi.org/health_care_redesign/diamond_35953/))
- Patient Centered Primary Care Collaborative: [www.pcpcc.net](http://www.pcpcc.net)
- Collaborative Family Healthcare Association: [www.CFHA.net](http://www.CFHA.net)
- AAFP's National Research Network [www.aafp.org/nrn/ccrn](http://www.aafp.org/nrn/ccrn)
- National Business Group on Health: "An Employer's Guide to Behavioral Health Services": [www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf](http://www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf)
- TEAM Care Program: [www.teamcarehealth.org/](http://www.teamcarehealth.org/)
- UW AIMS Center: <http://uwaims.org>

# Different models and approaches

- Different approaches are used in different settings.

We will review the evidence-base for collaborative care, and give examples of mature integrated care programs in different settings.

- Although the clinical models used vary somewhat, most effective approaches share a set of core principles.

# Principles of Effective Integrated Behavioral Health Care

"The core principles of effective integrated care include a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based 'treat-to-target' approach."

# Principles of Effective Integrated Behavioral Health Care

## Patient Centered Care

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## Population-Based Care

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# Psychiatry and Primary Care

## An evolving relationship:

### Consultative model

- Psychiatrists sees patients in consultation in his / her office – away from primary care.

### Co-located model

- Psychiatrist sees patients in primary care

### Collaborative model

- Psychiatrists takes responsibility for a caseload of primary care patients and works closely with PCPs and other primary care-based behavioral health providers.

# Traditional Consultation

## Limited access

- There will never be enough psychiatrists to refer all patients for consultation.

## Limited feedback

- PCPs experience psychiatry consultation as a 'black box'.

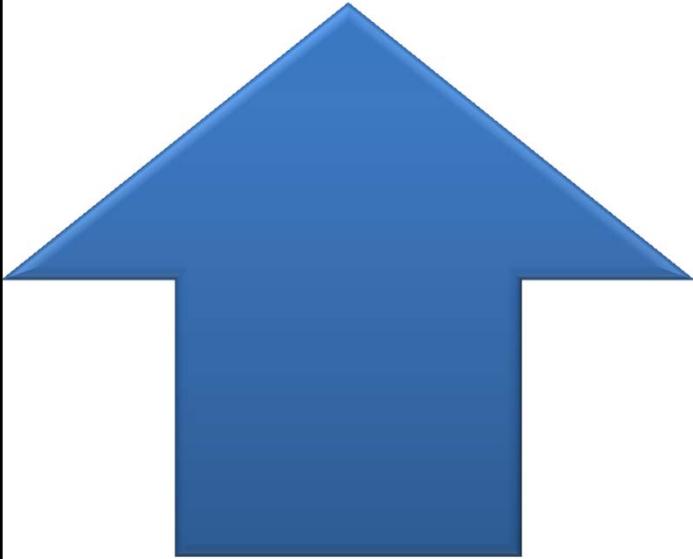
## Expensive

- All MH referrals require full intakes, often leaving little time and energy for follow-up or 'curbside consultation'.

## 'One Pass'

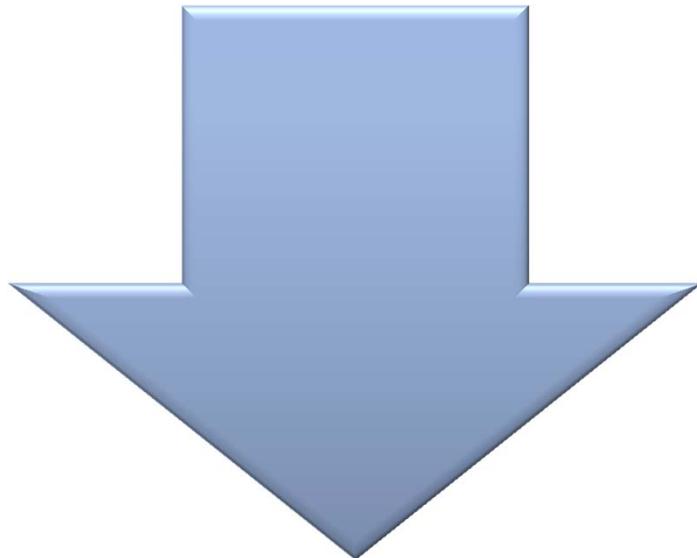
- Works best for one-time or acute issues that don't need follow-up.

# Co-Location



## **Psychiatrist comes to primary care.**

- Opportunity for interaction / curbside consultations
- Better communication (often same chart) and coordination / 'transfers' back to primary care.



## **BUT:**

- Not available in many settings (e.g., rural).
- Access still problematic: new slots fill up quickly; no shows; little capacity for follow-up.
- Limited ability to make sure recommendations are carried out.

# Collaborative Care

Caseload-focused psychiatric consultation supported by a care manager

## Better access

- PCPs get input on their patients' behavioral health problems within a days /a week versus months
- Focuses in-person visits on the most challenging patients.

## Regular Communication

- Psychiatrist has regular (weekly) meetings with a care manager
- Reviews all patients who are not improving and makes treatment recommendations

## More patients covered by one psychiatrist

- Psychiatrist provides input on 10 – 20 patients in a half day as opposed to 3-4 patients.

## ‘Shaping over time’

- Multiple brief consultations
- More opportunity to ‘correct the course’ if patients are not improving

# The Research Evidence for Collaborative Care

- Now over 69 Randomized Controlled Trials (RCTs)
  - Meta analysis of collaborative care (CC) for depression in primary care (US and Europe): CC is consistently more effective than usual care. (Thota et al, *Am J Prev Med* 2012; Gilbody S., *Arch Internal Med* 2006)
- Since 2006, several additional RCTs in new populations and for other common mental disorders
  - Including anxiety disorders, PTSD
- The IMPACT study is the largest research trial of integrated care to date.
  - 1,801 participants from 18 primary care clinics in 5 states randomly assigned to collaborative care or care as usual.



# Collaborative Care



**PCP supported by Behavioral Health Care Manager**

**Effective Collaboration**



**Informed, Active Patient**



**Practice Support**



**Measurement-based Stepped Care**



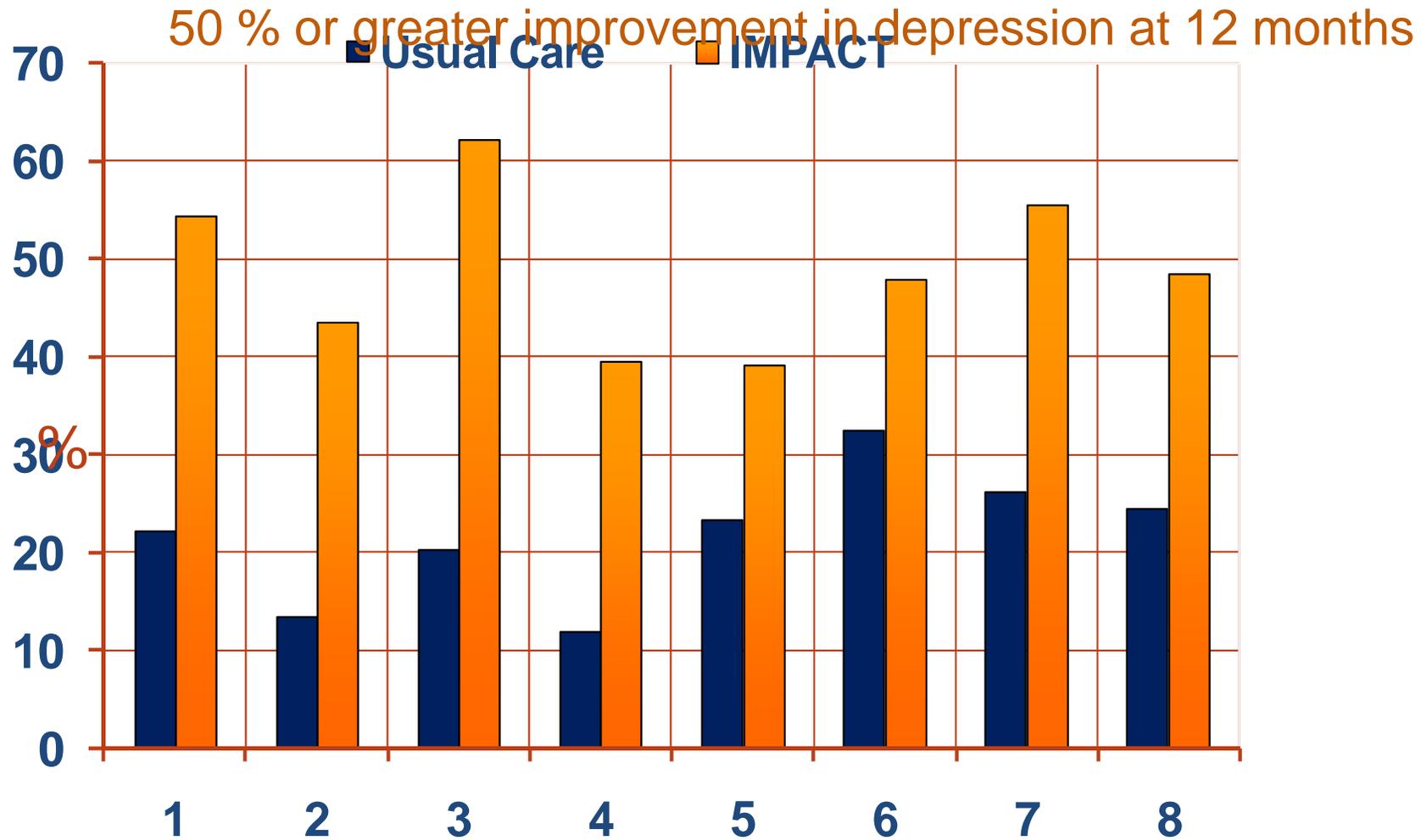
**Caseload-focused psychiatric consultation**



**Training**



# Doubles Effectiveness of Care for Depression

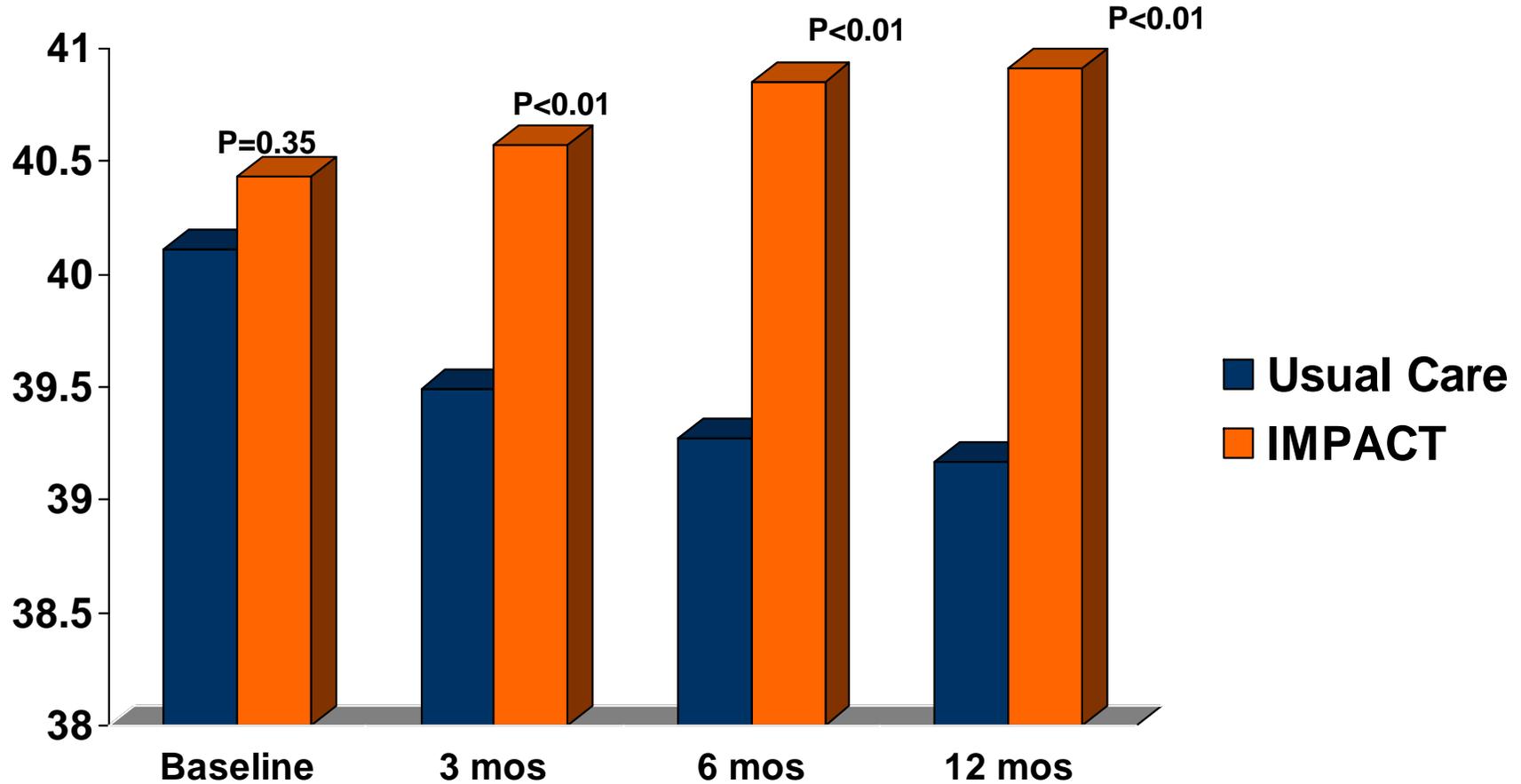


Participating Organizations



# Better Physical Function

## SF-12 Physical Function Component Summary Score (PCS-12)



Callahan et al., *JAGS* 2005; 53:367-373



# Long-Term Cost Savings

| Cost Category                                   | 4-year costs in \$ | Intervention group cost in \$ | Usual care group cost in \$ | Difference in \$ |
|-------------------------------------------------|--------------------|-------------------------------|-----------------------------|------------------|
| IMPACT program cost                             |                    | 522                           | 0                           | 522              |
| Outpatient mental health costs                  | 661                | 558                           | 767                         | -210             |
| Pharmacy costs                                  | 7,284              | 6,942                         | 7,636                       | -694             |
| Other outpatient costs                          | 14,306             | 14,160                        | 14,456                      | -296             |
| Inpatient medical costs                         | 8,452              | 7,179                         | 9,757                       | -2578            |
| Inpatient mental health / substance abuse costs | 114                | 61                            | 169                         | -108             |
| <b>Total health care cost</b>                   | <b>31,082</b>      | 29,422                        | 32,785                      | <b>-\$3363</b>   |

Savings

Unützer et al., *Am J Managed Care* 2008.

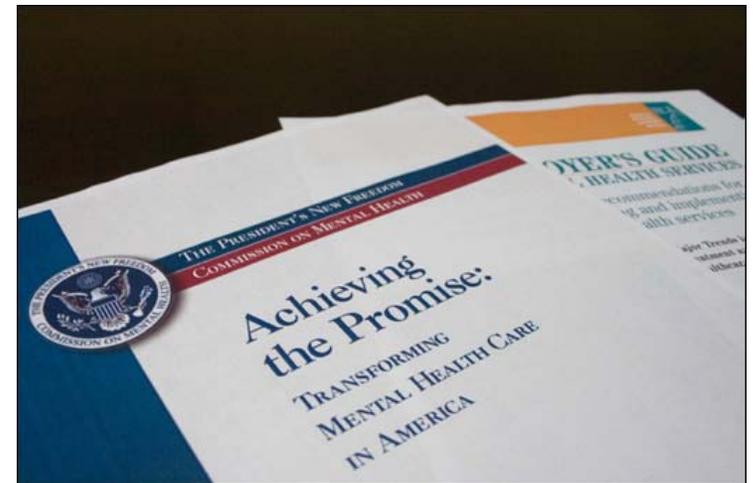


# IMPACT Replication Studies

| Patient Population<br>(Study Name)                               | Target<br>Clinical Conditions     | Reference                                       |
|------------------------------------------------------------------|-----------------------------------|-------------------------------------------------|
| Adult primary care patients<br>(Pathways)                        | Diabetes and depression           | Katon et al., 2004                              |
| Adult patients in safety net clinics<br>(Project Dulce; Latinos) | Diabetes and depression           | Gilmer et al., 2008                             |
| Adult patients in safety net clinics<br>(Latino patients)        | Diabetes and depression           | Ell et al., 2010                                |
| Public sector oncology clinic<br>(Latino patients)               | Cancer and depression             | Dwight-Johnson et al., 2005<br>Ell et al., 2008 |
| HMO patients                                                     | Depression in primary care        | Grypma et al., 2006                             |
| Adolescents in primary care                                      | Adolescent depression             | Richardson et al., 2009                         |
| Older adults                                                     | Arthritis and depression          | Unützer et al., 2008                            |
| Acute coronary syndrome patients<br>(COPEs)                      | Coronary events and<br>depression | Davidson et al., 2010                           |

# Endorsements for Collaborative Care

- IOM Report
- President's New Freedom Commission on Mental Health
- National Business Group on Health
- AHRQ Report
- CDC Consensus Panel
- SAMHSA
  - National Registry of Evidence-Based Programs & Practices (NREPP)



# Principles of Integrated Behavioral Health Care

## Patient Centered Care

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## Population-Based Care

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## Measurement-Based Treatment to Target

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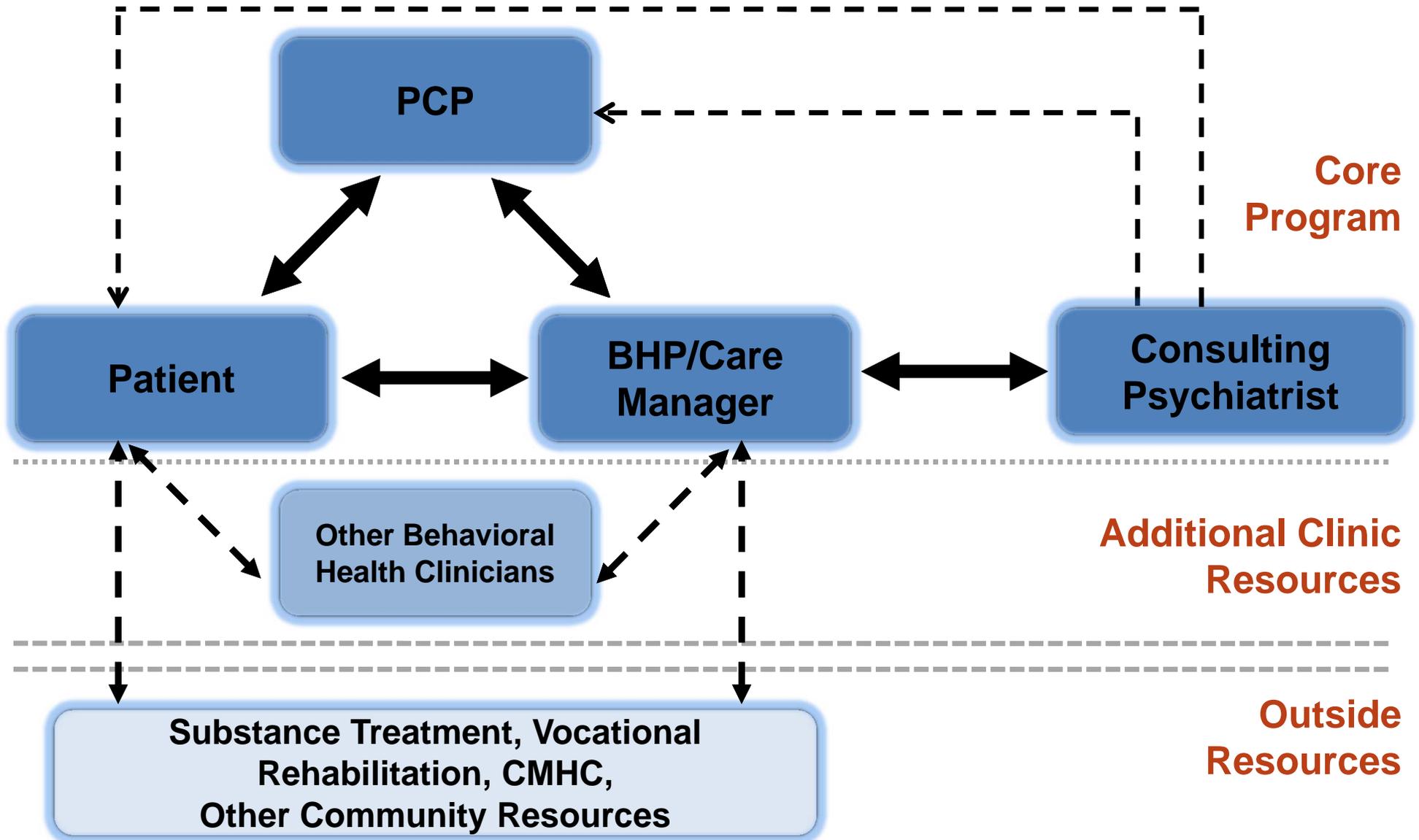
## Evidence-Based Care

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## Accountable Care

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# Collaborative Team Approach



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# Population-Focused

Public health approach

Assume responsibility for a defined population

Proactive, planned encounters

Prevent clients from falling through the cracks: the clients who 'no-show' may need the most attention

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# Measurement-Based Treatment to Target

Clinical treatment goals / core symptoms can be measured

- Like blood pressure or HgB A1c

Measurement gives information to clients and providers

- How will we know if treatments are effective?
- When is it time to consult or make changes in treatment?

# A 'real world' example of a 'mature' integrated care program: MHIP

**MHIP** for Behavioral Health  
Mental Health Integration Program



- Funded by State of Washington and Public Health Seattle & King County (PHSKC)
- Administered by Community Health Plan of Washington and PHSKC in partnership with the UW AIMS Center
- Initiated in 2008 in King & Pierce Counties & expanded to over 100 CHCs and 30 CMHCs state-wide in 2009.
- Over 20,000 clients served.

# http://integratedcare-nw.org

**MHIP** for Behavioral Health  
Mental Health Integration Program



[Login Operations](#) | [Login Clinical](#)

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**A Partnership to Promote Patient-Centered Collaboration**

**Community**

**Collaboration**

**Compassion**

**Care**

**Cost-effective**

## What is MHIP?

### Integration & Collaboration

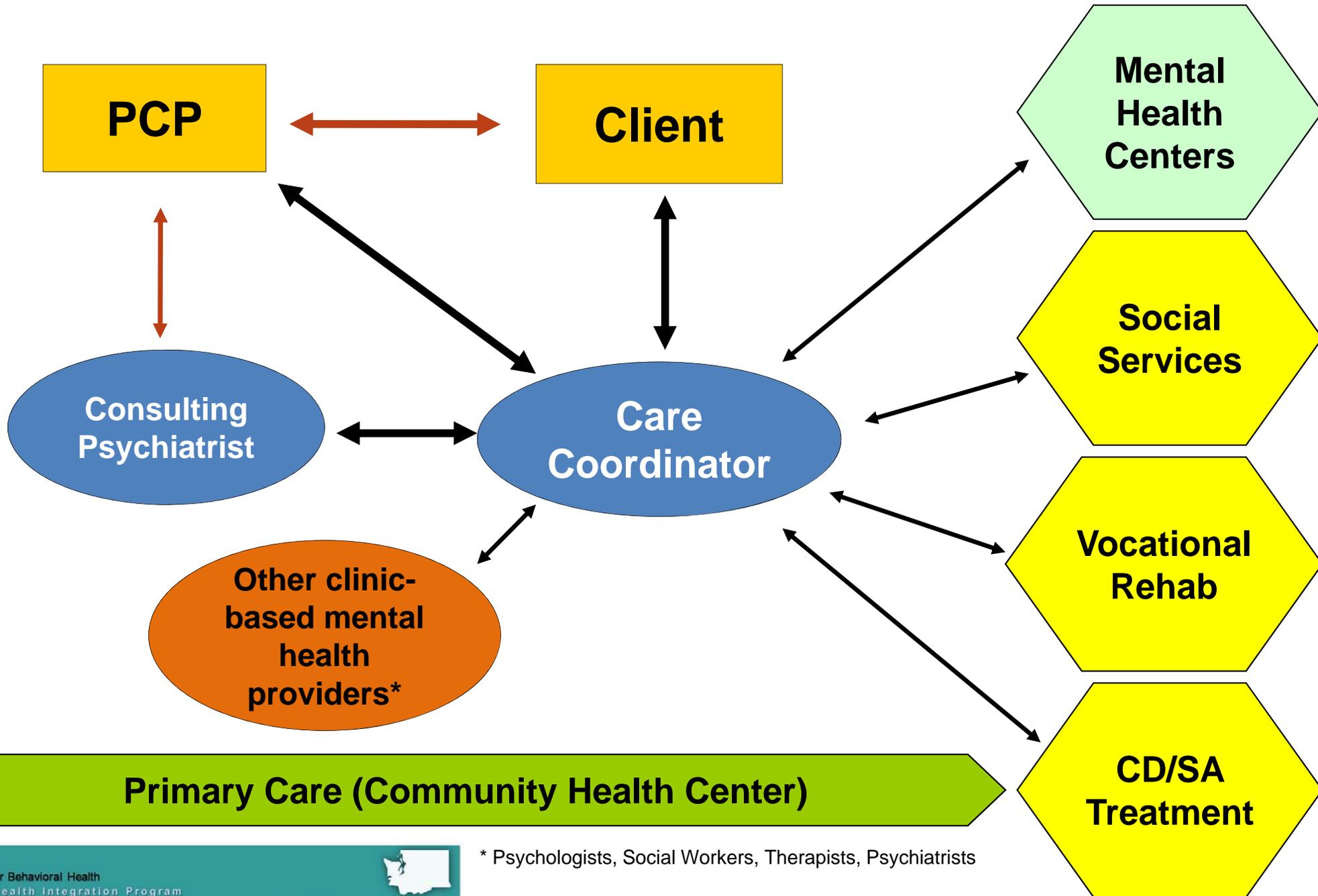
The **Mental Health Integration Program** is a *state-wide, patient-centered, integrated program* serving clients with medical, mental health, and substance abuse needs. The program provides:

- High quality mental health screening and treatment
- An evidence- and outcome-based *model* of collaborative stepped care to treat common mental disorders

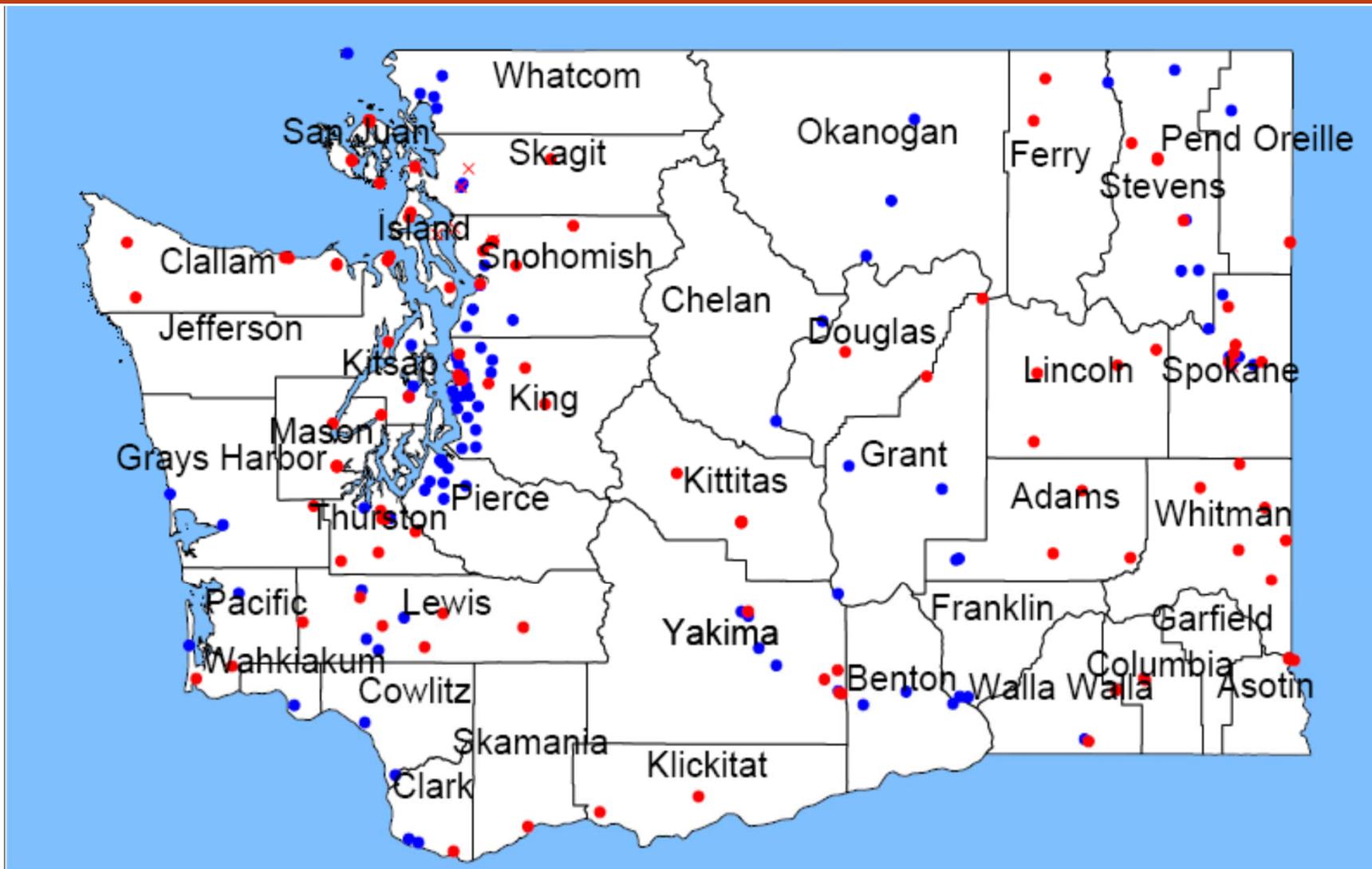
### Results-oriented



# MHIP Integrated Care Team



# MHIP: > 20,000 clients served across Washington State



# MHIP Client Demographics

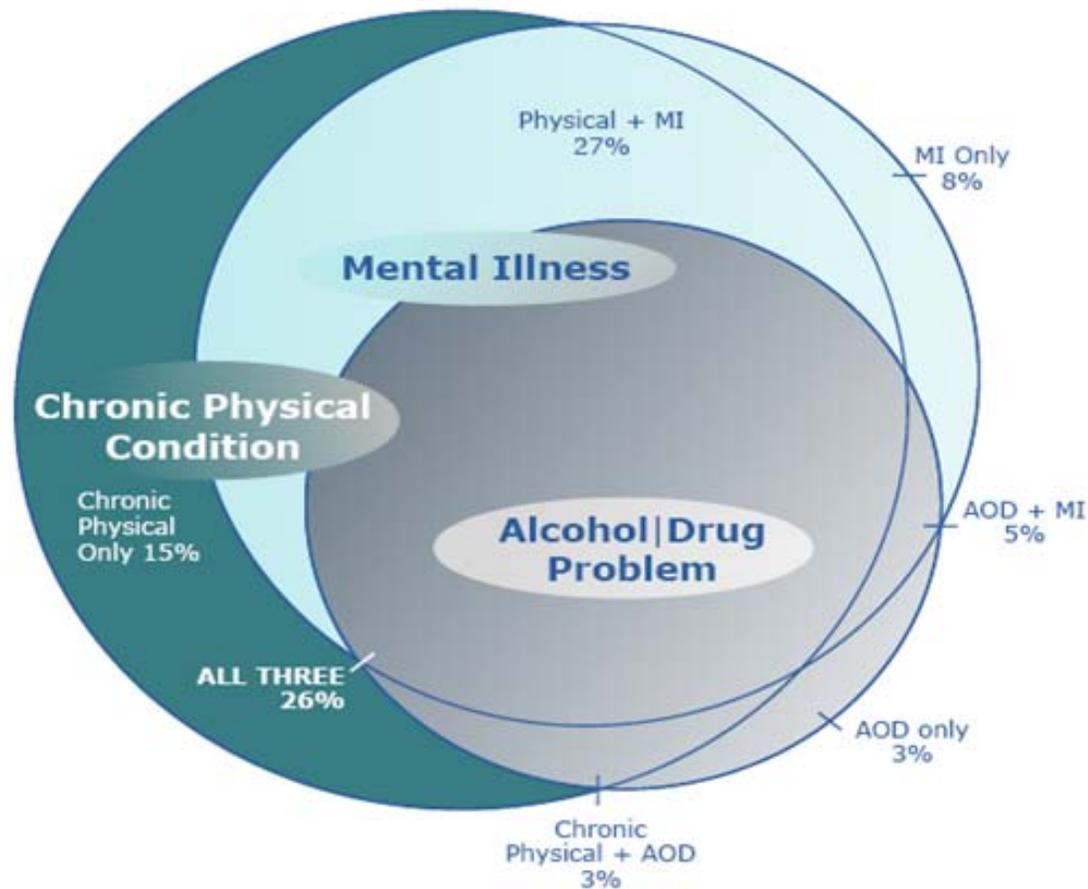
|                               | Mean or % | Range across clinics |
|-------------------------------|-----------|----------------------|
| Men                           | 52 %      |                      |
| Women                         | 48 %      |                      |
|                               |           |                      |
| Mean Age                      | 40        | 1-100                |
|                               |           |                      |
| Challenge with Housing        | 29 %      | 3% - 52 %            |
| Challenge with Transportation | 21 %      | 10 %- 50 %           |

# MHIP Co-Occurring Diagnoses

Co-occurring diagnosis among DL-U clients

**DISEASE CONDITIONS**

- Chronic Physical **71%**
- Mental Illness **66%**
- Substance Abuse **38%**



*72 percent had substance abuse or mental illness identified*

*15 percent had a chronic physical condition only*

*SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2006-07. Chronic physical and mental illness diagnosis groups derived from CDPS grouper. Mental illness also indicated by receipt of mental health medications.*

# MHIP Common Client Diagnoses

| Diagnoses                                                                                                                                         | %          |
|---------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Depression                                                                                                                                        | 71 %       |
| Anxiety (GAD, Panic)                                                                                                                              | 48 %       |
| Posttraumatic Stress Disorder (PTSD)                                                                                                              | 17 %       |
| Alcohol / Substance Abuse                                                                                                                         | 17 %*      |
| Bipolar Disorder                                                                                                                                  | 15 %       |
| <b>Thoughts of Suicide</b>                                                                                                                        | <b>45%</b> |
| ... plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, .... |            |

# MHIP Community Health Centers

(6 clinics; over 2,000 clients served)

| Population          | Mean baseline PHQ-9 depression score | Follow-up (%) | Mean number of care coordinator contacts | % with psychiatric case-review consultation | % with significant clinical improvement |
|---------------------|--------------------------------------|---------------|------------------------------------------|---------------------------------------------|-----------------------------------------|
| Disability Lifeline | 16 / 27                              | 92 %          | 8                                        | 69%                                         | 43 %                                    |
| Uninsured           | 15 / 27                              | 83 %          | 8                                        | 59%                                         | 50 %                                    |
| Older Adults        | 15 / 27                              | 92 %          | 8                                        | 55%                                         | 43 %                                    |
| Vets & Family       | 15 / 27                              | 92%           | 7                                        | 54%                                         | 53%                                     |
| Mothers             | 15 / 27                              | 81%           | 7                                        | 50 %                                        | 60%                                     |

Data from Mental Health Integrated Tracking System (MHITS)

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# MHIP: Evidence-Based Treatments

**MHIP** for Behavioral Health  
Mental Health Integration Program



- Training for participating primary care and behavioral health providers in evidence-based treatments
- Psychiatric recommendations for evidence-based use of psychotropic medications
- Brief evidence-based psychosocial interventions such as motivational interviewing and behavioral activation in primary care
- Referral for other evidence-based behavioral health or substance abuse treatments as needed.
- See <http://integratedcare-nw.org>

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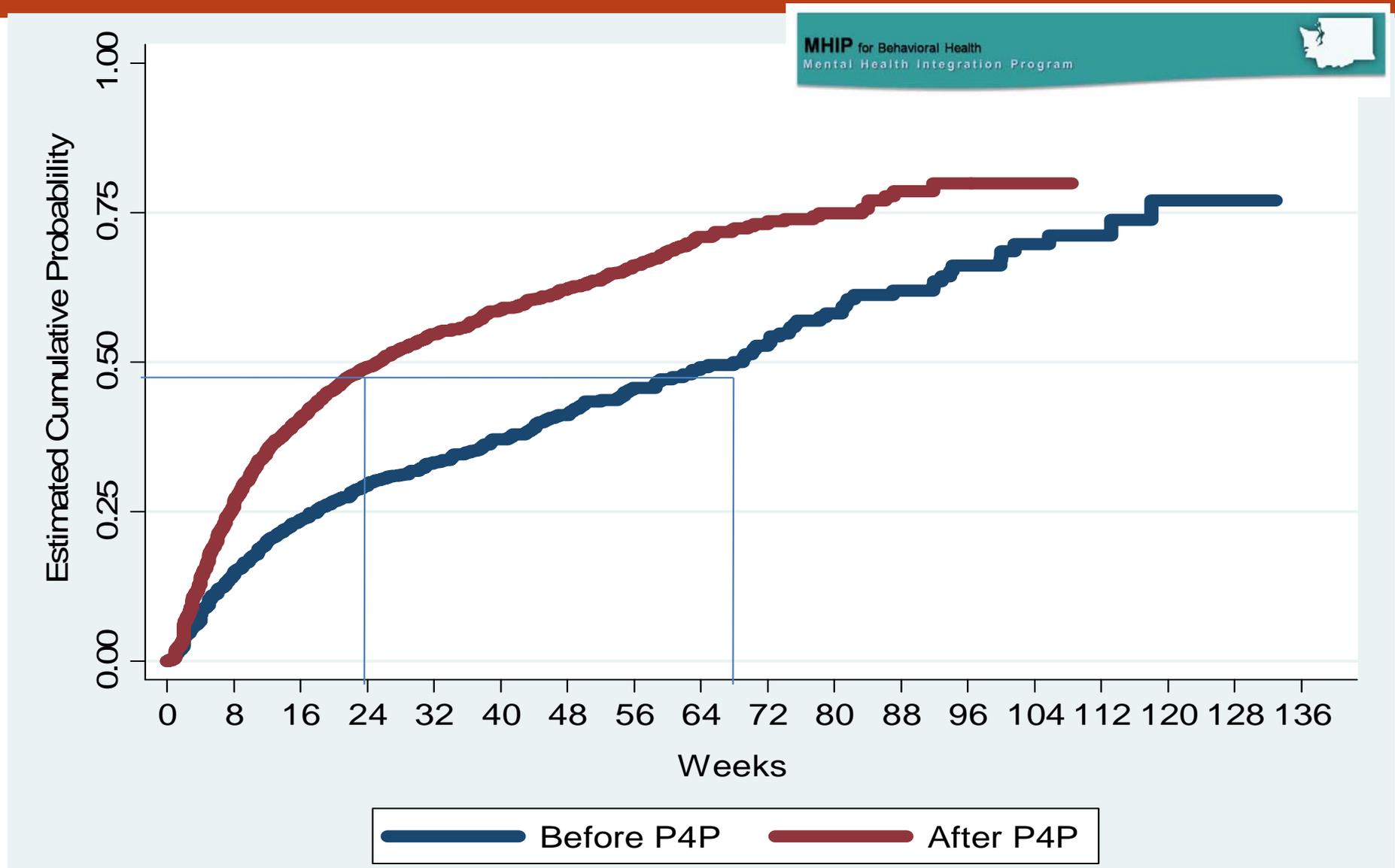
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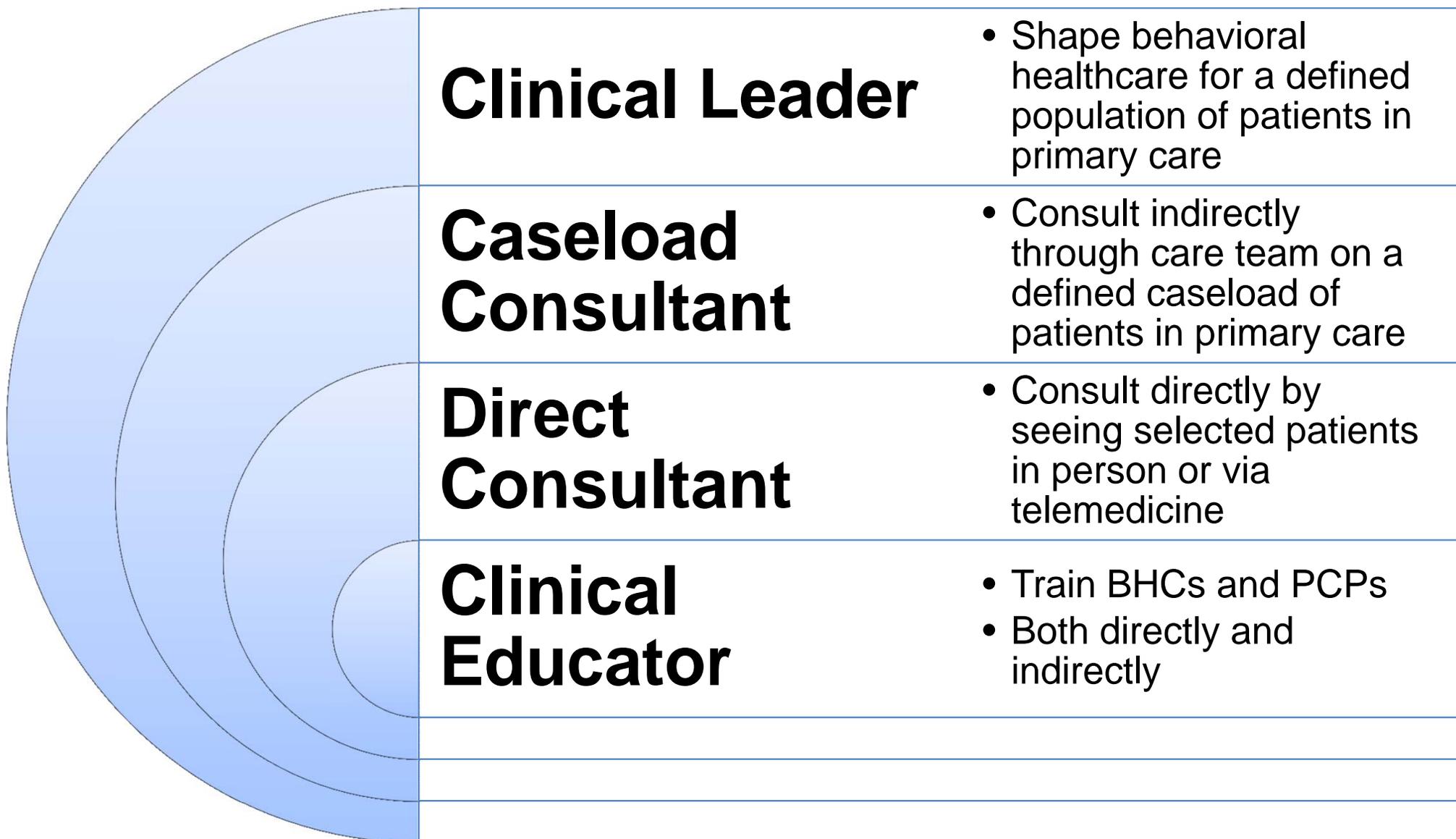
- Providers are accountable and reimbursed for quality of care, clinical outcomes, and patient satisfaction, not just the volume of care provided.

# MHIP: Pay-for-performance-based quality improvement cuts median time to depression treatment response in half.



Unutzer et al, Am J Public Health. 2012

# Roles of the Primary Care Consulting Psychiatrist



# Consulting Psychiatrists Experiences

***Consulting in primary care has been wonderful 'time off the hamster wheel'.***

*... an opportunity for doing something other than 15-20 minute med evaluations*

*... to be involved in shaping the provision of mental health care for a large population of patients in primary care*

*... to teach*

# 'Day in the life' of a part-time primary care consulting psychiatrist

8 AM -12 PM:

- **Duties in a community mental health center or other clinical setting:**
  - Clinical and administrative
  - Available for urgent curbside consultations from primary care

12 PM -1 PM :

- **Lunch:** 30 min discussion of clinical topic with PCPs during provider meeting.

1 PM - 5 PM:

- **Duties as primary care consultant including:**
  - Work with BHP/Care managers
  - Clinic visits and monthly integrated care team meeting for caseload review, QI, and strategic planning

# 'Day in the life' of a full-time primary care consulting psychiatrist

8 AM -10 AM:

- Systematic caseload-based review of patients who challenging or not improving with care manager and recommendations to PCPs

10 AM – 12PM:

- Direct patient consultation / care (in person or via telemedicine)

12 PM -1 PM :

- Lunch: 30 min discussion of clinical topic with PCPs during provider meeting.

1 PM -2 PM:

- Return calls and questions from care managers and / or PCPs; curbside consultation with PCPs.

2PM - 4 PM:

- Direct patient consultation / care (in person or via telemedicine)

4 PM - 5 PM:

- Monthly integrated care team meeting for caseload review, QI, and strategic planning

# Common Questions and Concerns

- **How do I get started in this work?**
- **How do I 'bridge the cultures' of primary care and mental health?**
- **How to get paid for doing this?**
- **What about liability?**

# Define the Scope of Practice and Negotiate a Contract

**MHIP** for Behavioral Health  
Mental Health Integration Program



## Job Description: University of Washington Consulting Psychiatrist Mental Health Integration Program (MHIP)

### JOB SUMMARY

The consulting psychiatrist is responsible for supporting mental health care provided by primary care providers and care coordinators treating MHIP patients in participating community health centers (CHCs) or other primary care clinics.

### DUTIES AND RESPONSIBILITIES

1. Provide regularly scheduled (usually weekly) caseload consultation to assigned care coordinators (CCs). These consultations will primarily focus on patients who are new to treatment or who are not improving as expected.
2. Provide telephonic consultation to primary care physicians (PCPs) as requested, focusing on patients in the CCs caseload.
3. Work with the assigned CCs to track and oversee their patient panels and clinical outcomes using the web-based MHITS care management tracking system.

See <http://uwaims.org> for sample job description.

# What About Liability for Collaborative Care?

## **PCPs**

The PCP oversees overall care of the patient and retains overall liability for care provided. This includes assessment, diagnosis and treatments provided (e.g., prescription of psychotropic medications).

Using a systematic integrated team care model in which a care manager supports the PCP by using evidence-based tools to help facilitate assessment, providing systematic, measurement-based follow-up, and a psychiatric consultant who can advise on diagnostic or treatment questions should reduce the risk to the patient and 'liability exposure' of the PCP.

## **Other clinic-based team members**

Care managers and other clinic-based behavioral health team members are responsible for the care they provide within their scope of practice / license.

## **Psychiatric consultant**

The psychiatric consultant may

1. provide advice as part of a 'curbside consultation' that does not involve the patient directly => very limited liability (see Olick et al, Fam Med 2003).
2. see patient for a direct consultation (either in-person or via telemedicine), in which case they are liable for the content of the assessment and treatment recommendations they provide as part of this consultation.

Should negotiate liability coverage as part of practice arrangement / contract.

# Malpractice Liability for Informal ('curbside') Consultations

Robert S. Olick, JD, PhD; George R. Bergus, MD, MAEd

From the Center for Bioethics and Humanities, SUNY Upstate Medical University (Dr Olick); and the Department of Family Medicine and the Department of Psychiatry, University of Iowa (Dr Bergus). *Fam Med* 2003;35(7):476-81.

**Background:** *Informal ("curbside") consults are widely used by primary care physicians. These interactions occur in person, by telephone, or even by e-mail. Exposure to malpractice liability is a frequent concern of subspecialty physicians and influences their willingness to engage in this activity. To assess this risk, we reviewed reported judicial opinions involving informal consultation by physicians.*

**Methods:** *A search of the existing medical literature, and of the Westlaw® national database was undertaken to identify reported judicial opinions involving informal physician consults that address whether informal consultations create a legal relationship between consulting specialist physicians and patients that gives rise to a legal duty of care owed by the consulting specialist to the patient.*

**Conclusions:** *Courts have consistently ruled that no physician-patient relationship exists between a consultant and the patient who is the focus of the informal consultation. In the absence of such a relationship, the courts have found no grounds for a claim of malpractice. Malpractice risks associated with informal consultation appear to be minimal, regardless of the method of communication. While "informal consultation" is not a term used by the courts, the courts have applied a consistent set of criteria that help define the legal parameters of this activity.*

# Be clear about limitations: sample 'disclaimer' statement

“The above treatment considerations and suggestions are based on consultations with the patient’s care manager and a review of information available in the Care Management Tracking System (CMTS). **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 about the care of this patient. “

Dr. x, Consulting Psychiatrist

Phone #.

Pager #.

E-mail

# How do I get paid?

## Two payment mechanisms for consulting psychiatrists in primary care:

- 1) Fee-for-service payment for consultations in which patients are directly evaluated / treated.
- 2) Contract with health plan or clinic / medical group for time to provide systematic caseload-based review and consultation.
  - Direct contract to psychiatrist for time (e.g., 3-4 hours / week / FTE care manager)
  - Psychiatrist time contract as part of a monthly case rate payment (e.g., DIAMOND program in Minnesota) :  
[http://www.icsi.org/health\\_care\\_redesign\\_/diamond\\_35953/](http://www.icsi.org/health_care_redesign_/diamond_35953/)

# Reflection Questions

## Reflective Thinking

- Is primary care psychiatry for me?
  - Clinical leadership role at interface of mental health and the rest of health care?
  - Enjoy sharing, communication, and teaching?
  - Can live with uncertainty common in primary care?
- Are there unmet needs in my community or clinic that could be addressed with a more effectively integrated behavioral health program?

## Adapt to Practice (including team building)

- Describe your current practice in relationship to primary care and think about how you could implement and support evidence-based collaborative care programs / principles in your setting.

# Resources

## For consulting psychiatrists:

- AIMS Center: <http://uwaims.org>
- APA: <http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/FinancingHealthcare/Integrated-Care-Resources.aspx>

## Resources to provide to your team:

- Information for PCPs from Washington State Integrated Care Program: <http://integratedcare-nw.org>
- CIHS : [http://www.thenationalcouncil.org/cs/center\\_for\\_integrated\\_health\\_solutions](http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions)
- Patient Centered Primary Care Collaborative: <http://www.pcpcc.net>

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# Questions?

