Mental Health Care in Primary Care Settings

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The SAMHSA/HRSA Center for Integrated Health Solutions

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Goals and Objectives

Mental Health in Primary Care Settings

- Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care.
- Discuss principles of integrated behavioral health care.
- Describe the roles for a primary care consulting psychiatrist in an integrated care team.
- Apply a primary care oriented approach to psychiatric consultation for common behavioral health presentations.

Why behavioral health care in primary care?

1. **Access to care and reach:**

   Serve patients where they are

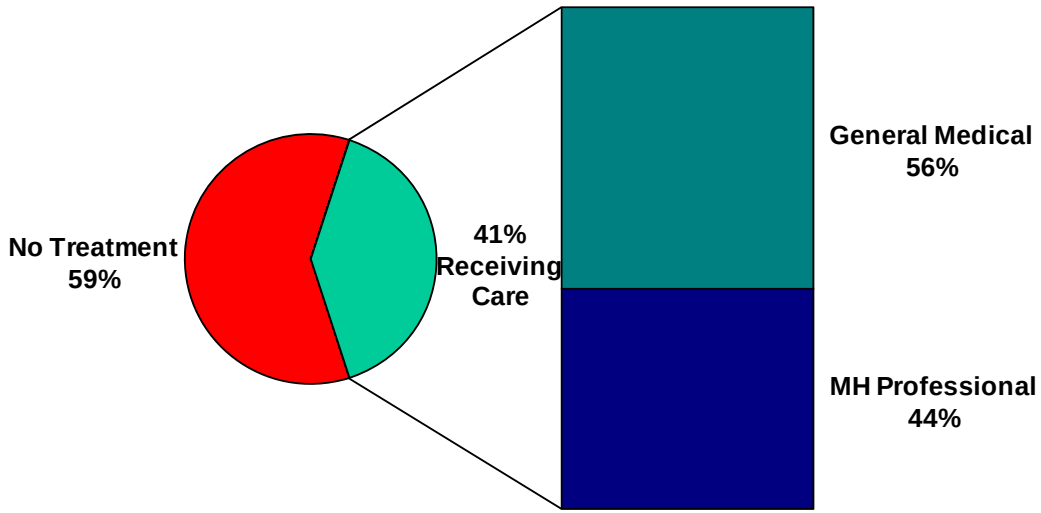
2. **Patient-centered care:**

   Treat the 'whole patient'

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

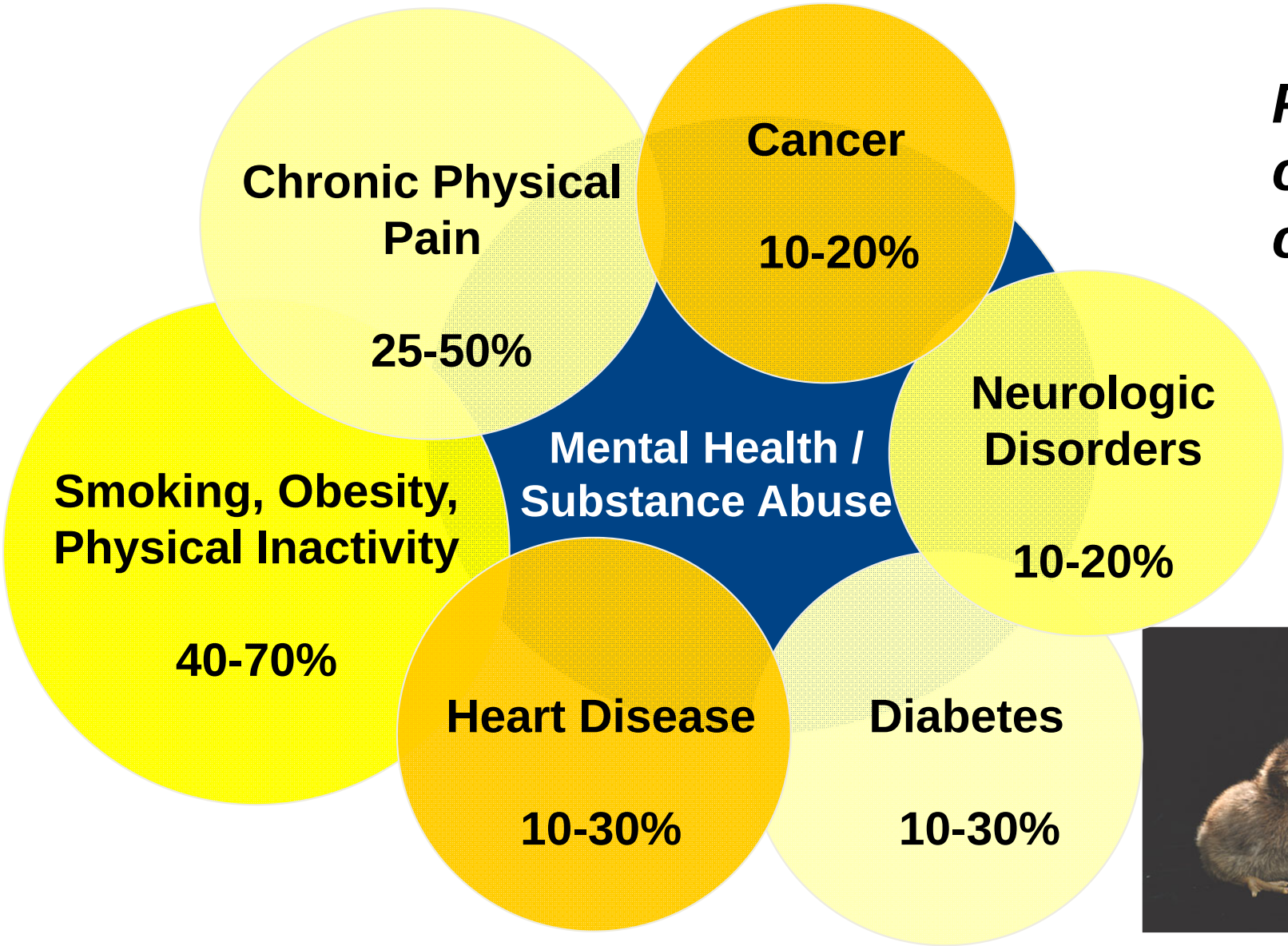
BUT

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

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

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

Mental Disorders are Rarely the Only Health Problem



Patient-centered care?

Services are poorly coordinated.

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

Life of a Busy PCP

Challenges:

- Large patient panels (1,500 – 2,500)
- Fast paced: 20-30 encounters / day
- Huge range of problems / responsibilities
  - Full range of medical, behavioral, social problems
  - Acute care, chronic care, prevention

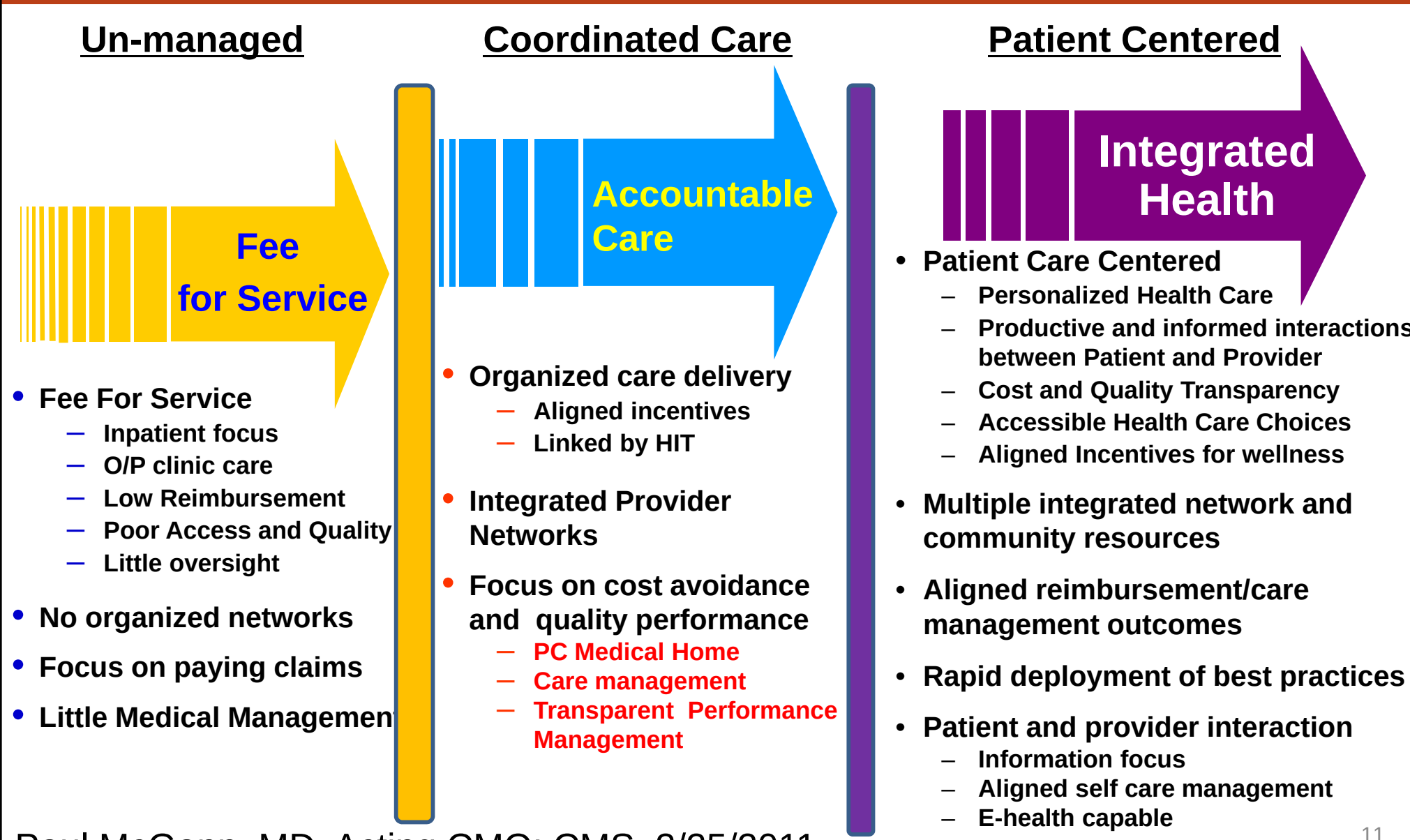
"Everything comes at me and I bat at the problem before me" → hard to keep track of what happens once treatments started

Ways to cope:

- Focus:
  - What is the most serious?
  - What is practical to accomplish today?
- Diagnose and treat 'over time'
- Get help → TEAMWORK

Need practical solutions & effective communication → COLLABORATIVE CARE

Health Care Reform:
Moving towards coordinated / integrated care.



Paul McGann, MD. Acting CMO; CMS. 2/25/2011

Principles of Effective 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’.

Accountable Care

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

The Research Evidence for Collaborative Care

- Over 69 Randomized Controlled Trials (RCTs)
- Meta-analysis by Gilbody S., *Archives of Internal Medicine*; Dec 2006
  - 37 trials of collaborative care (CC) for depression in primary care (US and Europe): CC is consistently more effective than usual care.
- 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

Practice Support

Informed, Active Patient

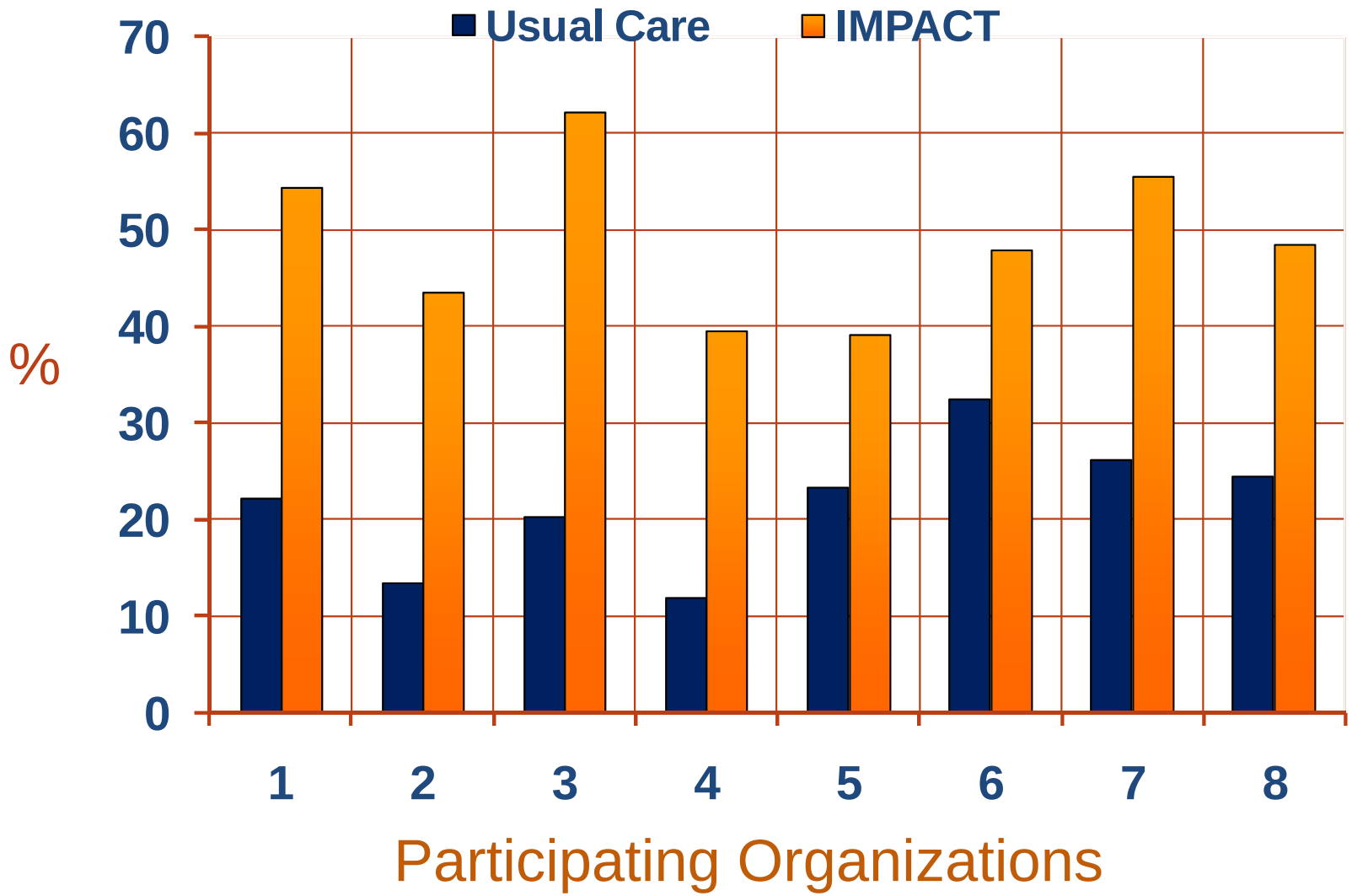
Measurement-based Stepped Care

Caseload-focused psychiatric consultation

Training

Doubles Effectiveness of Care for Depression

50 % or greater improvement in depression at 12 months



Unützer et al., JAMA 2002; Psych Clin North America 2004

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
Total health care cost	**31,082**	29,422	32,785	**-$3363**

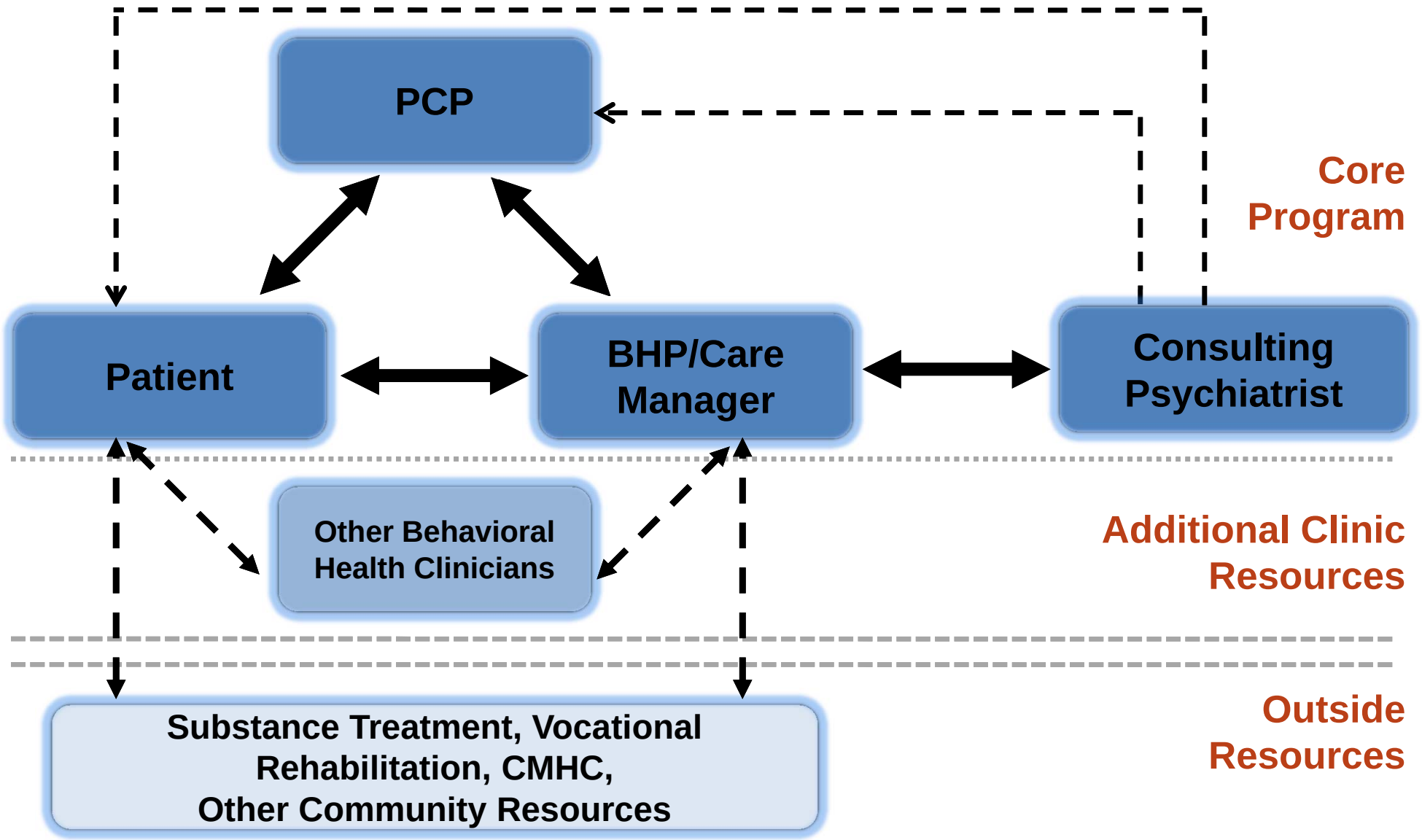
Savings

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

IMPACT Replication Studies

Patient Population (Study Name)	Target Clinical Conditions	Reference
Adult primary care patients (Pathways)	Diabetes and depression	Katon et al., 2004
Adult patients in safety net clinics (Project Dulce; Latinos)	Diabetes and depression	Gilmer et al., 2008
Adult patients in safety net clinics (Latino patients)	Diabetes and depression	Ell et al., 2010
Public sector oncology clinic (Latino patients)	Cancer and depression	Dwight-Johnson et al., 2005 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 (COPES)	Coronary events and depression	Davidson et al., 2010

Collaborative Team Approach



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

Home Map Partners The Model Training Evaluation Stories News

A Partnership to Promote Patient-Centered Collaboration

Community Collaboration Compassion Care Cost-effective

What is MHIP?

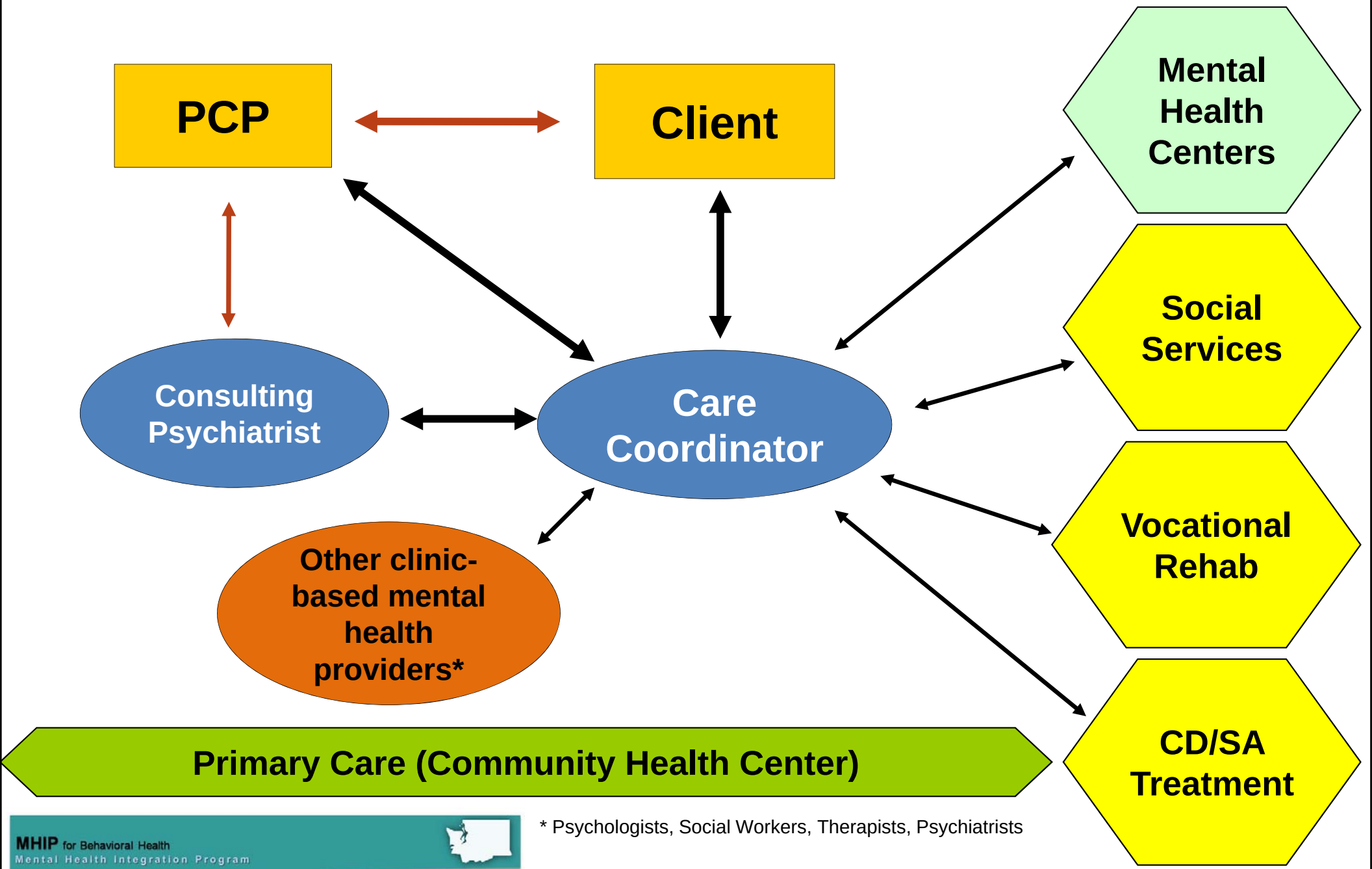
Integration & Collaboration

The **M**ental **H**ealth **I**ntegration **P**rogram 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

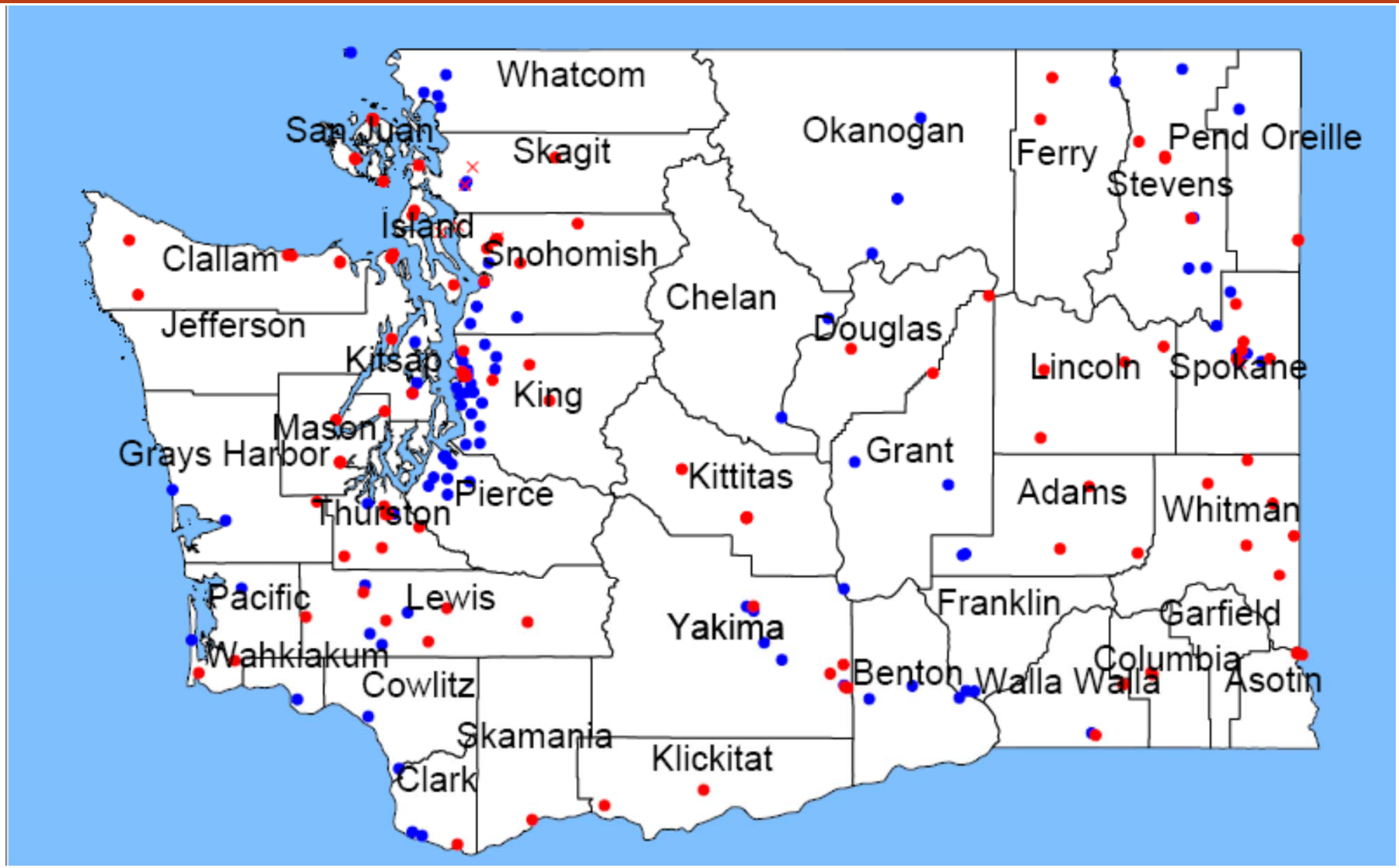
MHIP Integrated Care Team



* Psychologists, Social Workers, Therapists, Psychiatrists

MHIP for Behavioral Health
Mental Health Integration Program

MHIP: > 25,000 clients served across Washington State



MHIP for Behavioral Health
Mental Health Integration Program

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 %

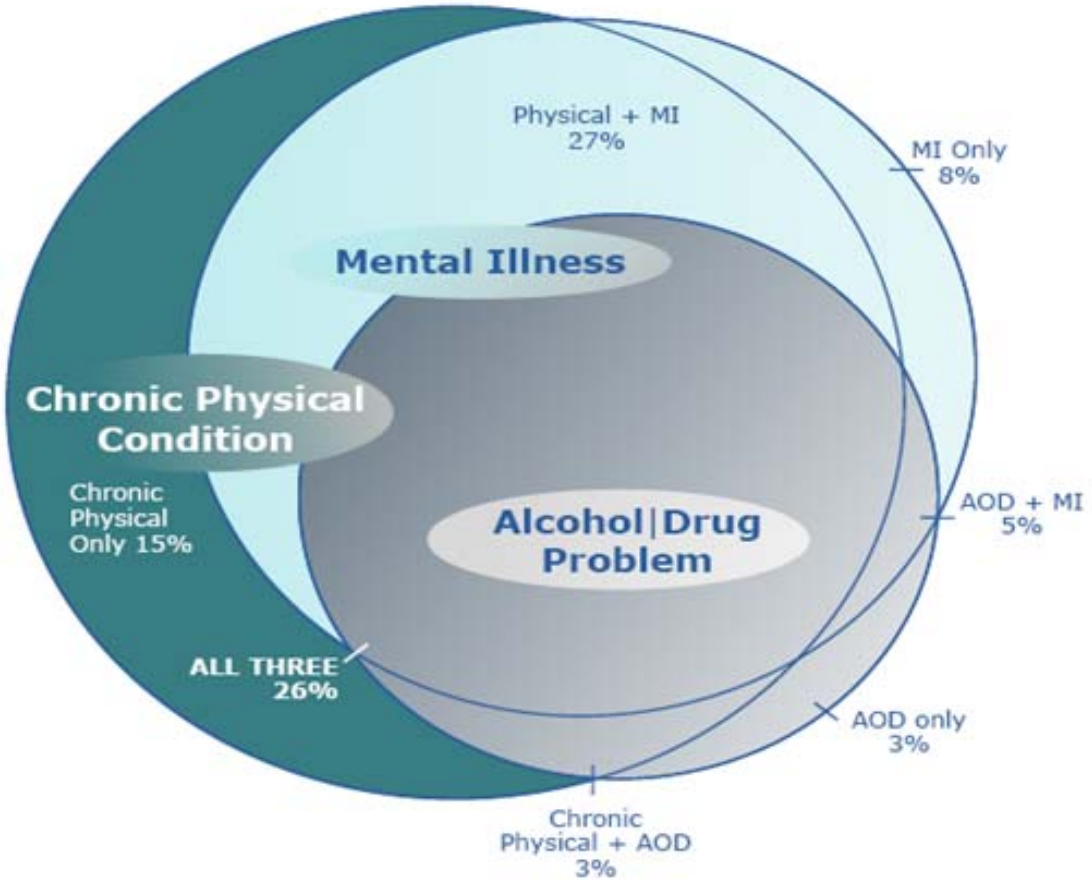
MHIP Co-Occurring Diagnoses

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*

Co-occurring diagnosis among DL-U clients



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 for Behavioral Health
Mental Health Integration Program

Washington State Senate Ways and Means January 31, 2011

MHIP Common Client Diagnoses

Diagnoses	%
Depression	71 %
Anxiety (GAD, Panic)	48 %
Posttraumatic Stress Disorder (PTSD)	17 %
Alcohol / Substance Abuse	17 %*
Bipolar Disorder	15 %
Thoughts of Suicide	45%

… 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 psych iatric 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%

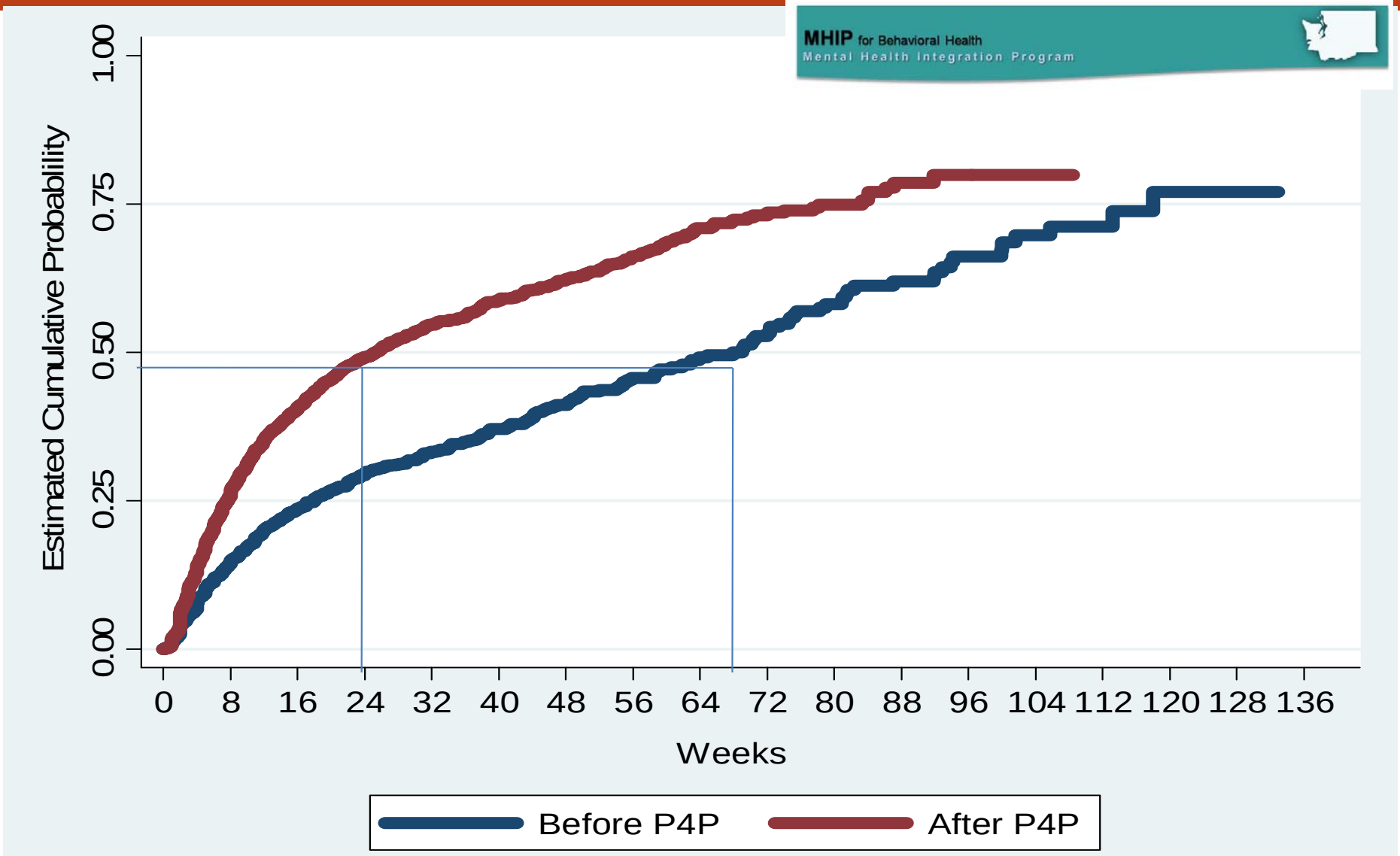
Data from Mental Health Integrated Tracking System (MHITS)

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

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



Unutzer et al, Am J Public Health. 2012

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’.

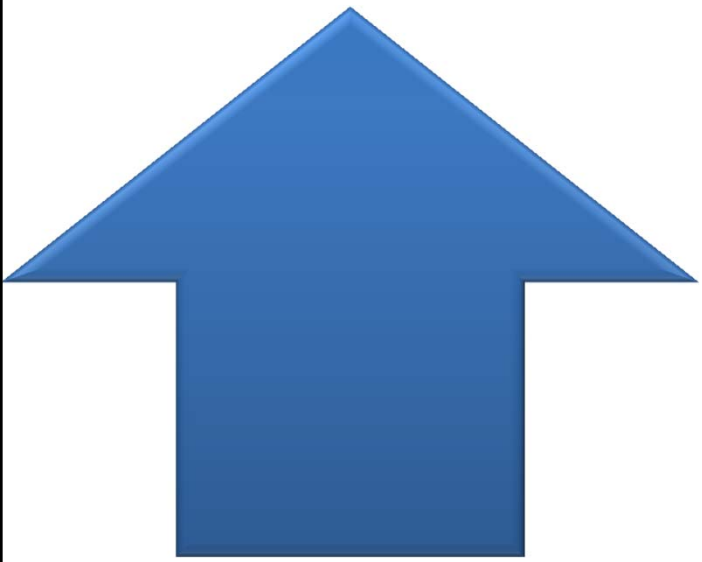
Expensive

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

‘One Pass’

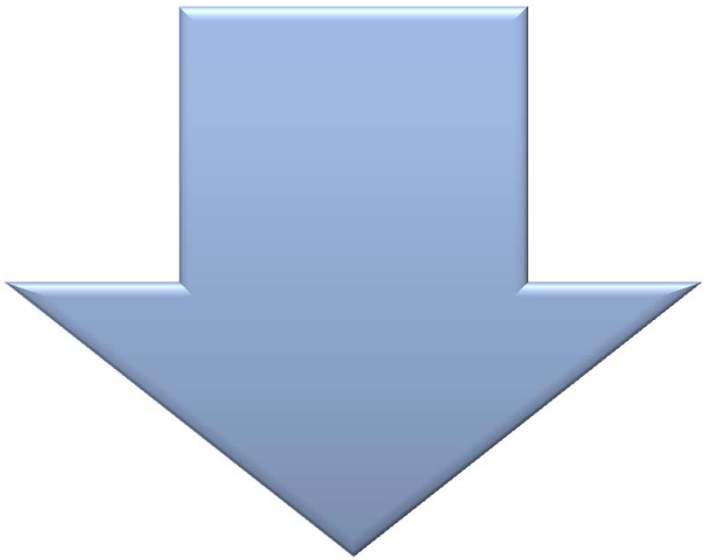
- Works best for one-time or acute issues that don’t need follow-up.

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

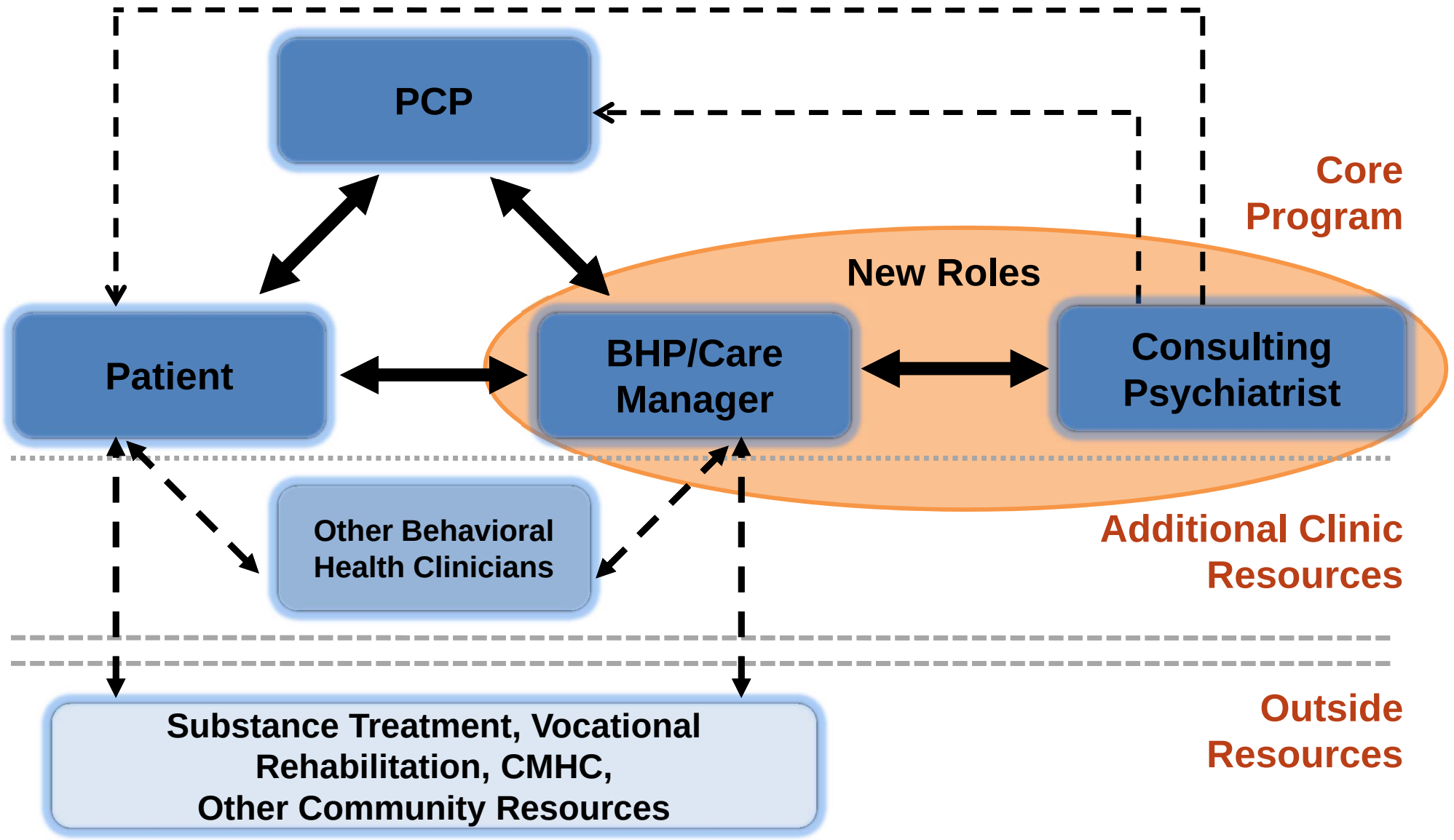
More patients covered by one psychiatrist

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

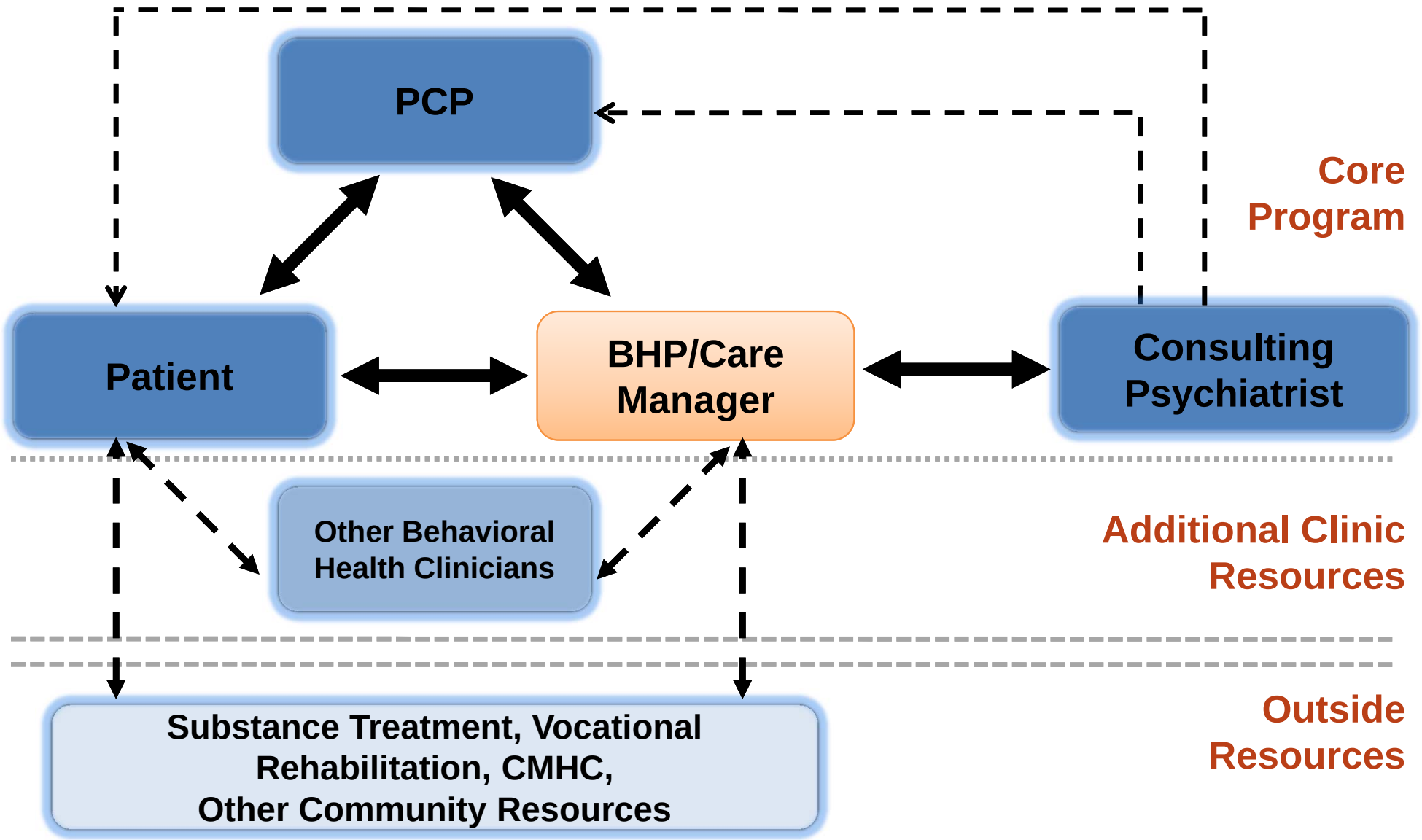
'Shaping over time"

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

Collaborative Team Approach



BHP/ Care Manger



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

Other Skills

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

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?

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

Caseload Consultation vs Caseload Supervision

Caseload Consultation

-Discuss overall caseload

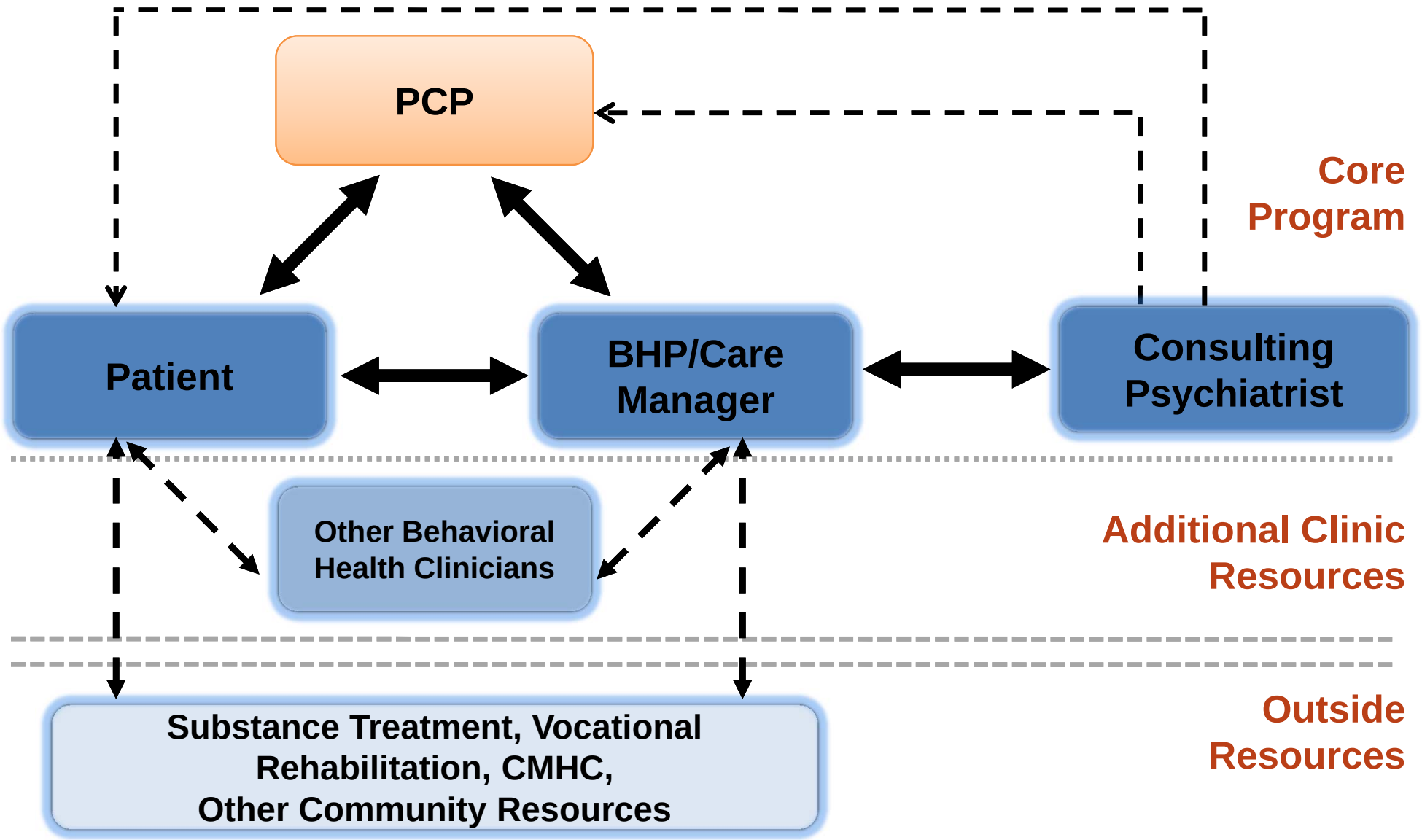
-Specific case reviews

- Diagnostic clarification
- Treatment planning
- Medication recommendation

Caseload Supervision

- Discuss reactions to patients
- May involve specific therapy planning

Primary Care Provider



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

- 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

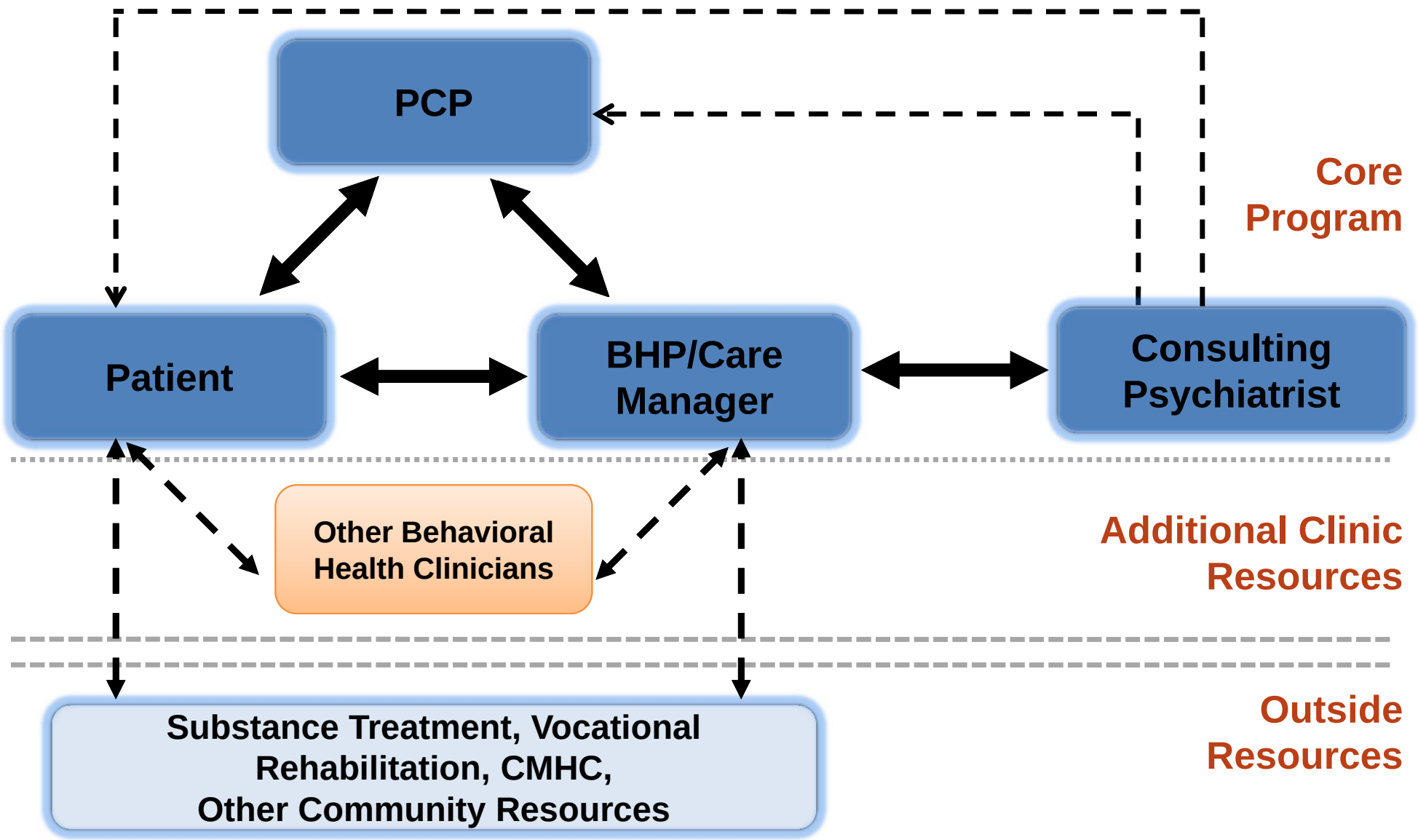
Recommendations

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

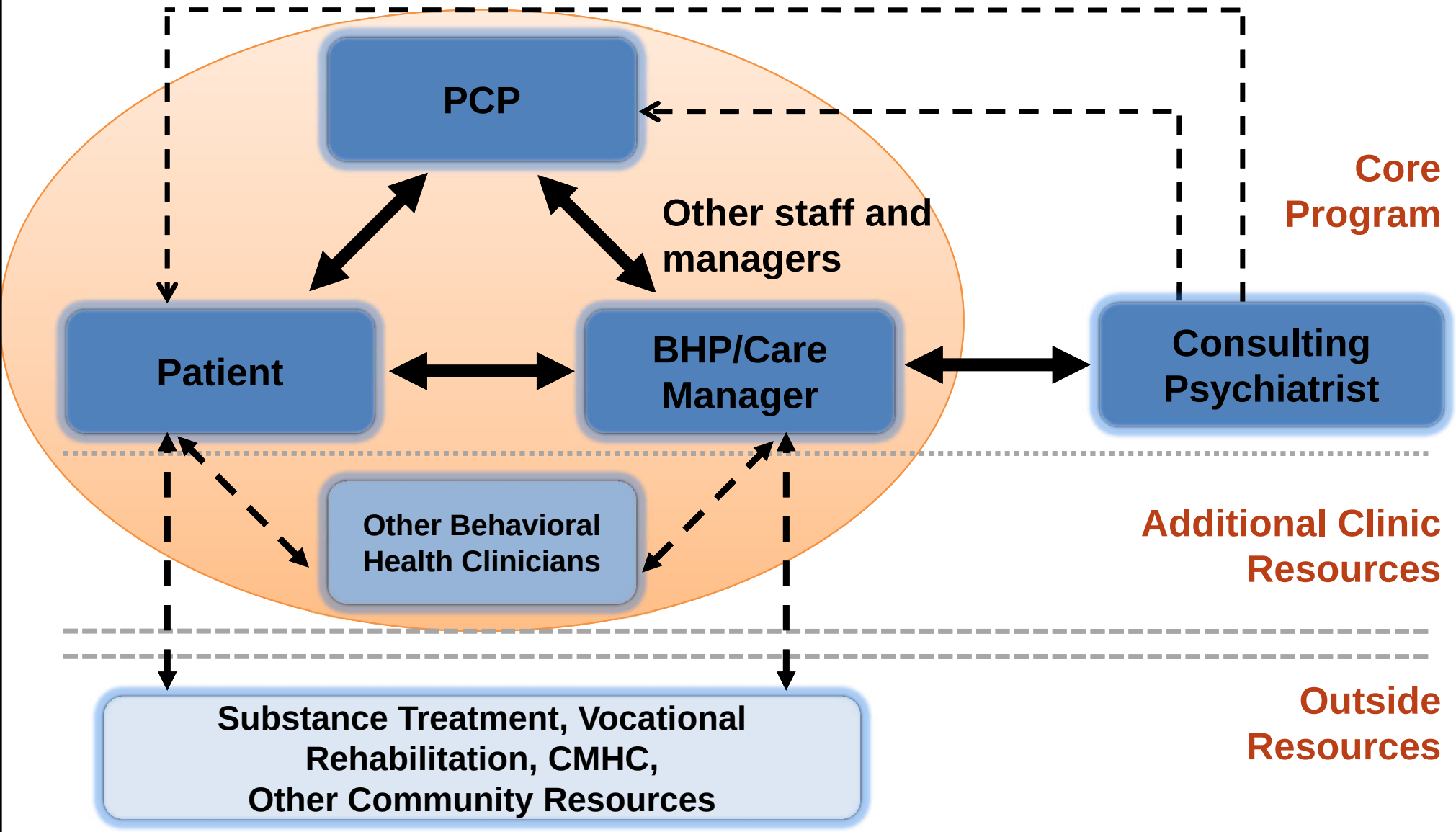
Provide Education

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

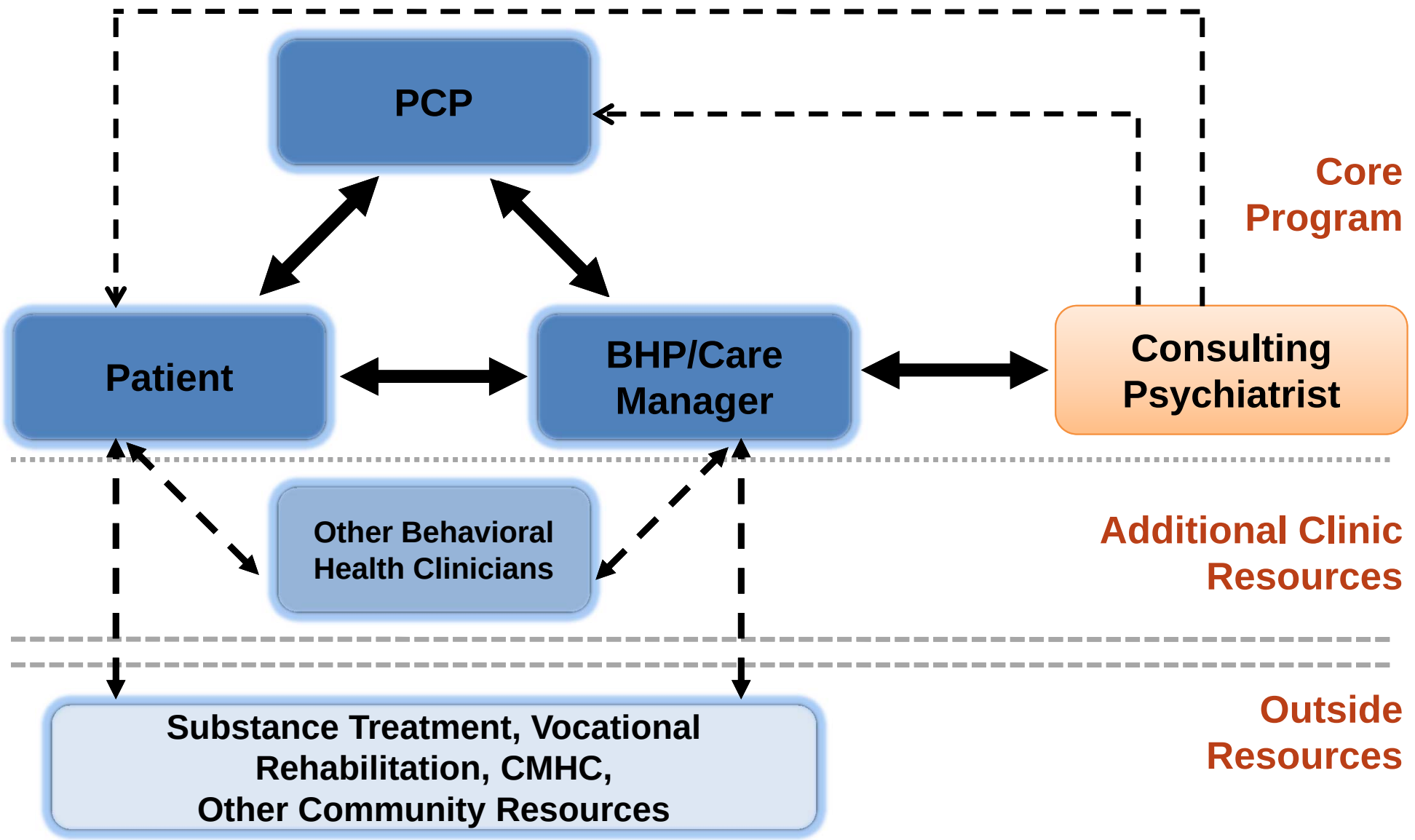
Other Behavioral Health Clinicians



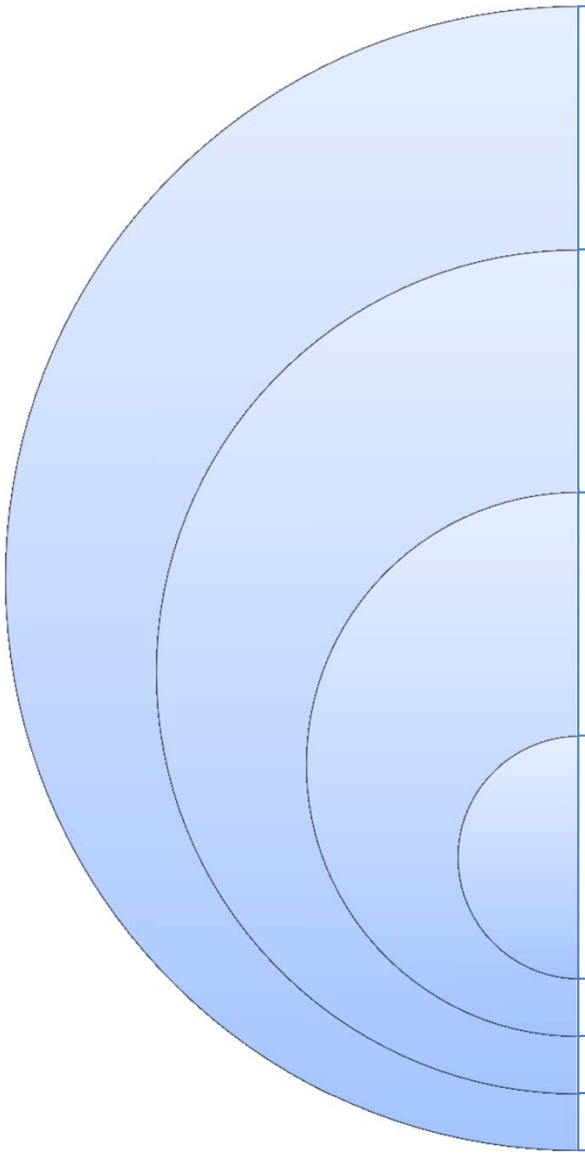
‘Silent’ Partners



Consulting Psychiatrist



Roles of the Primary Care Consulting Psychiatrist



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 in person or via telemedicine
Clinical Educator	• Train BHCs and PCPs • Both directly and indirectly

Leading the Development of an Integrated Care Program

- Understand the environment
  - The world of primary care
  - Find and nurture a primary care "champion”
- Identify current resources
  - Team building tools
- Create and support your team
- Develop a clinical workflow

Consulting Psychiatrist Leadership

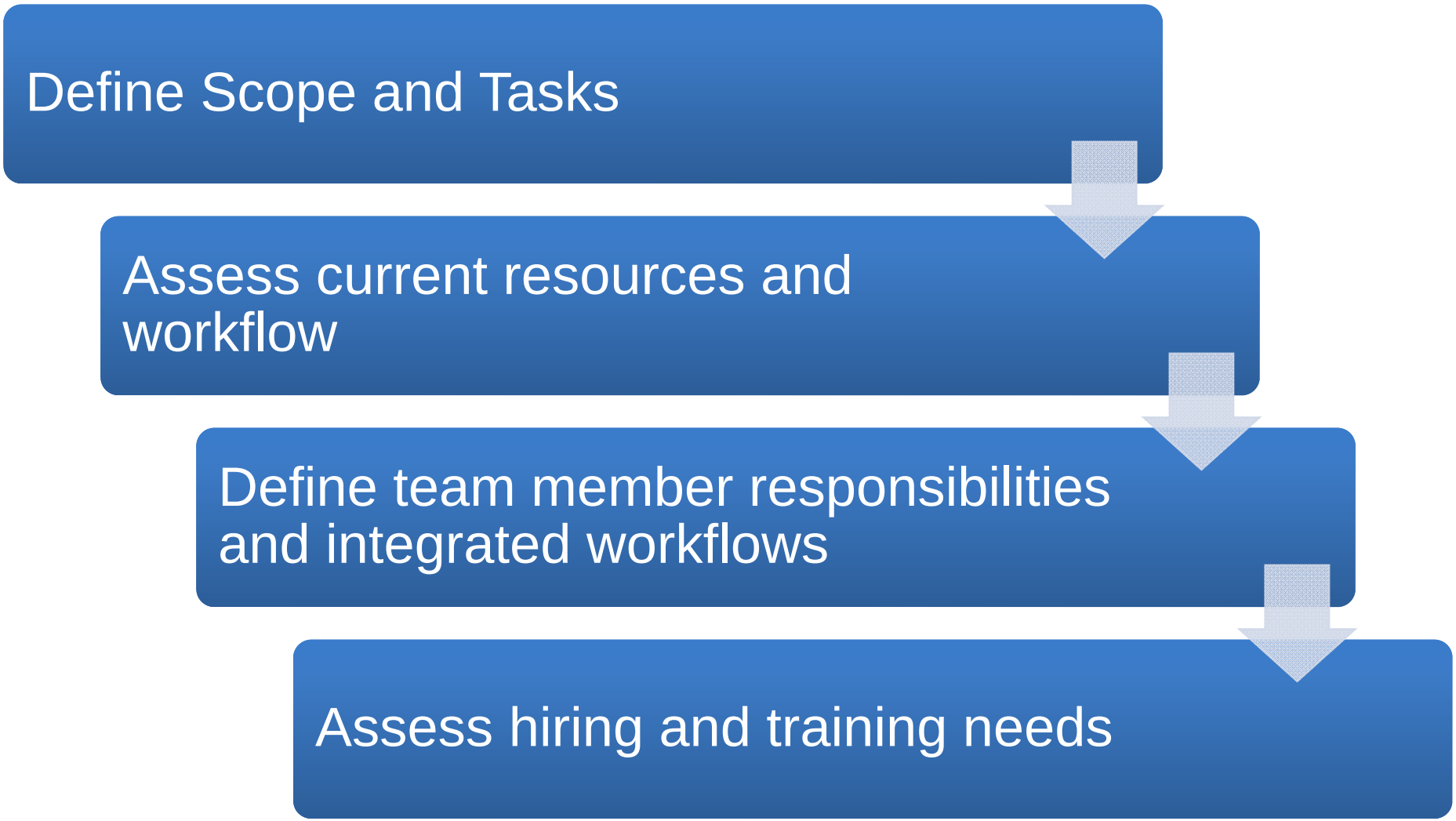
Administrative Leadership

- Negotiate the scope of integrated care practice, contract and payment
- Identify and cultivate the primary care champions and partners
- Help build the collaborative care team
- Support the collaborative care team

Clinical Leadership

- Facilitate the development of clinical protocols
  - e.g., suicidal ideation, psychiatric emergencies, use of controlled substances (benzos, opiates), management of chronic pain
- Facilitate team approach to challenging patients

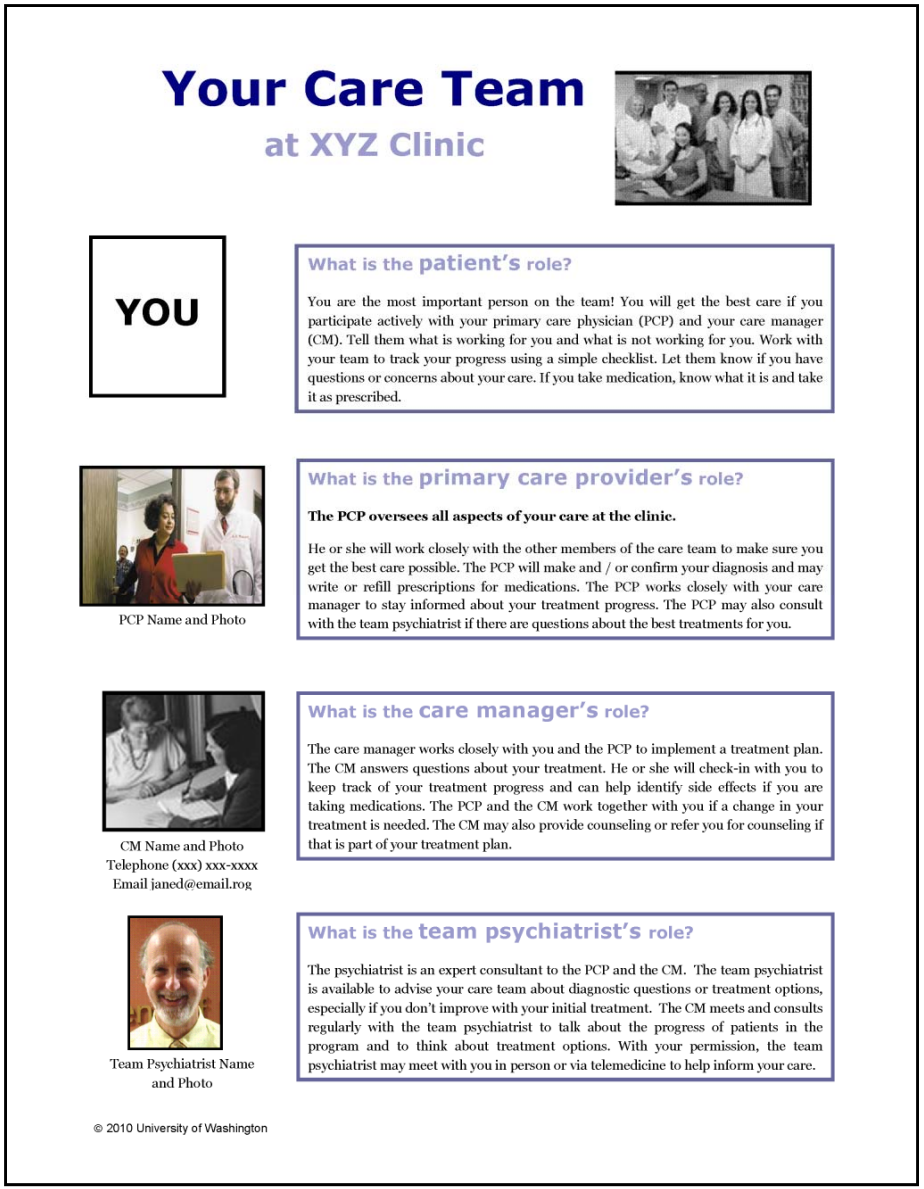
Team Building Process



Integrated Care: Core Components and Tasks

“Your Care Team Template”

- **Combine with other patient educational materials**
- **Customize template:**
  - Insert staff photos and contact information
  - Put assessment tool (e.g. PHQ-9) on back
  - Make into tri-fold brochure and include other general information for patients



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?

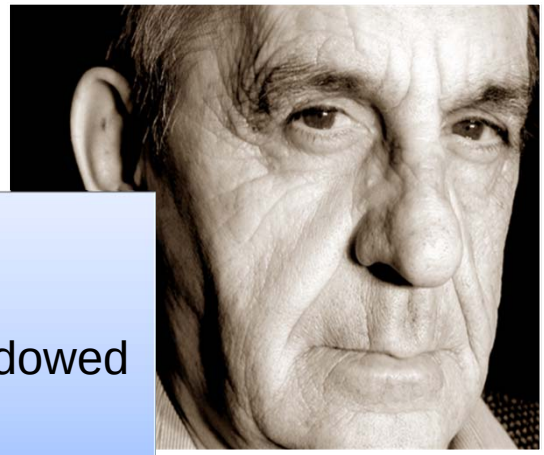
The care manager works closely with you and the PCP to implement a treatment plan. The CM answers questions about your treatment. He or she will check-in with you to keep track of your treatment progress and can help identify side effects if you are taking medications. The PCP and the CM work together 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

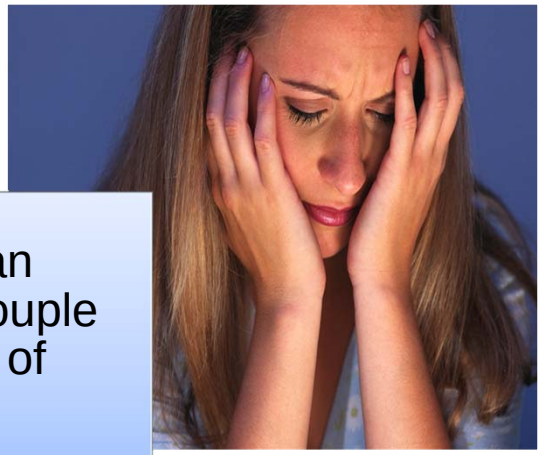
What is the team psychiatrist’s role?

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.

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

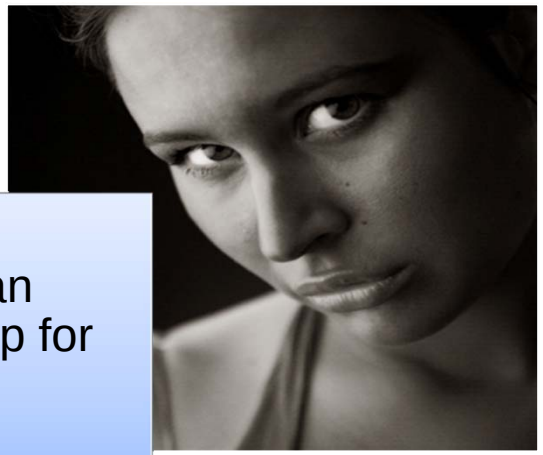


67yo man recently widowed



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”

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

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**

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: _____

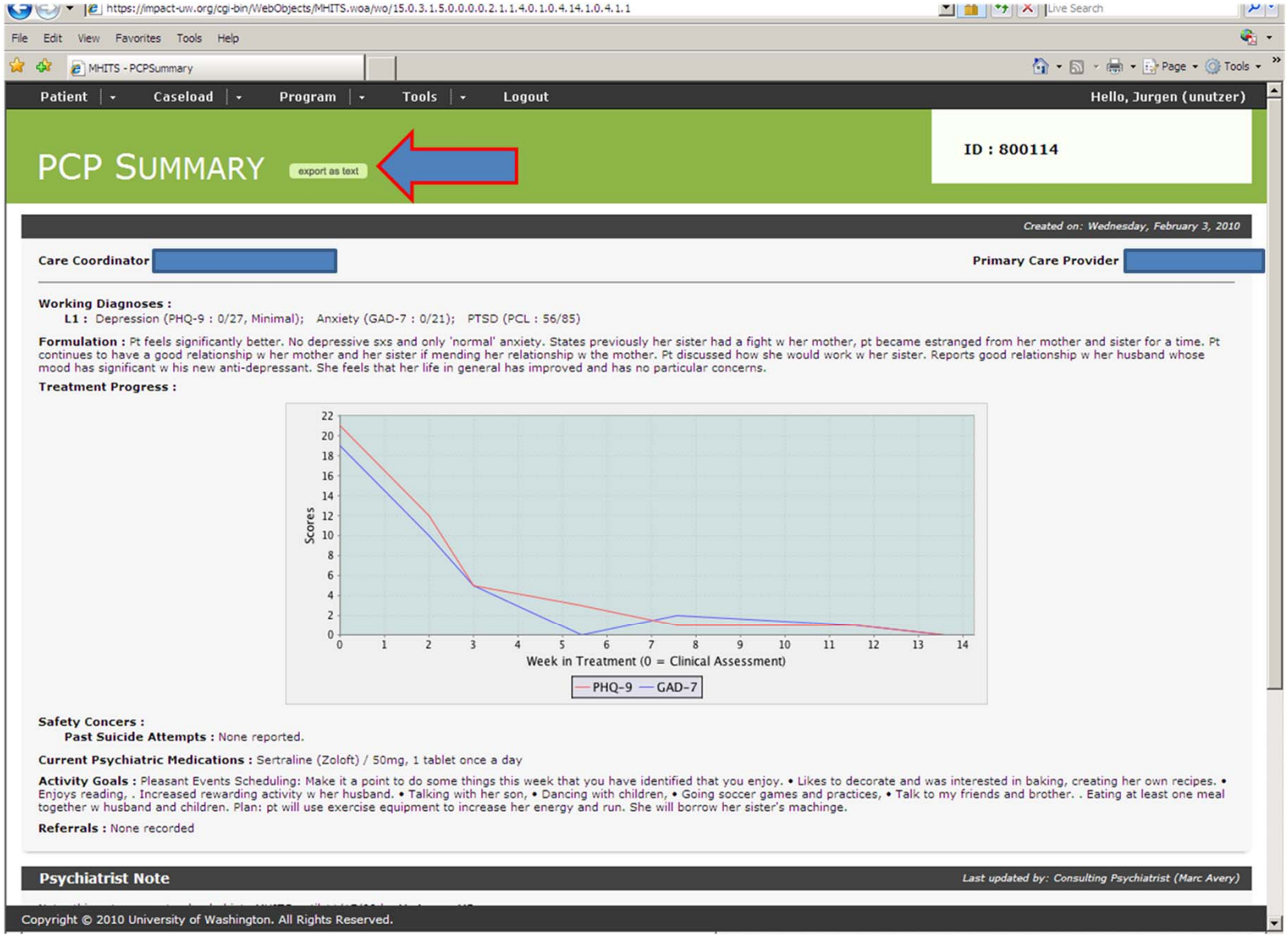
Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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	

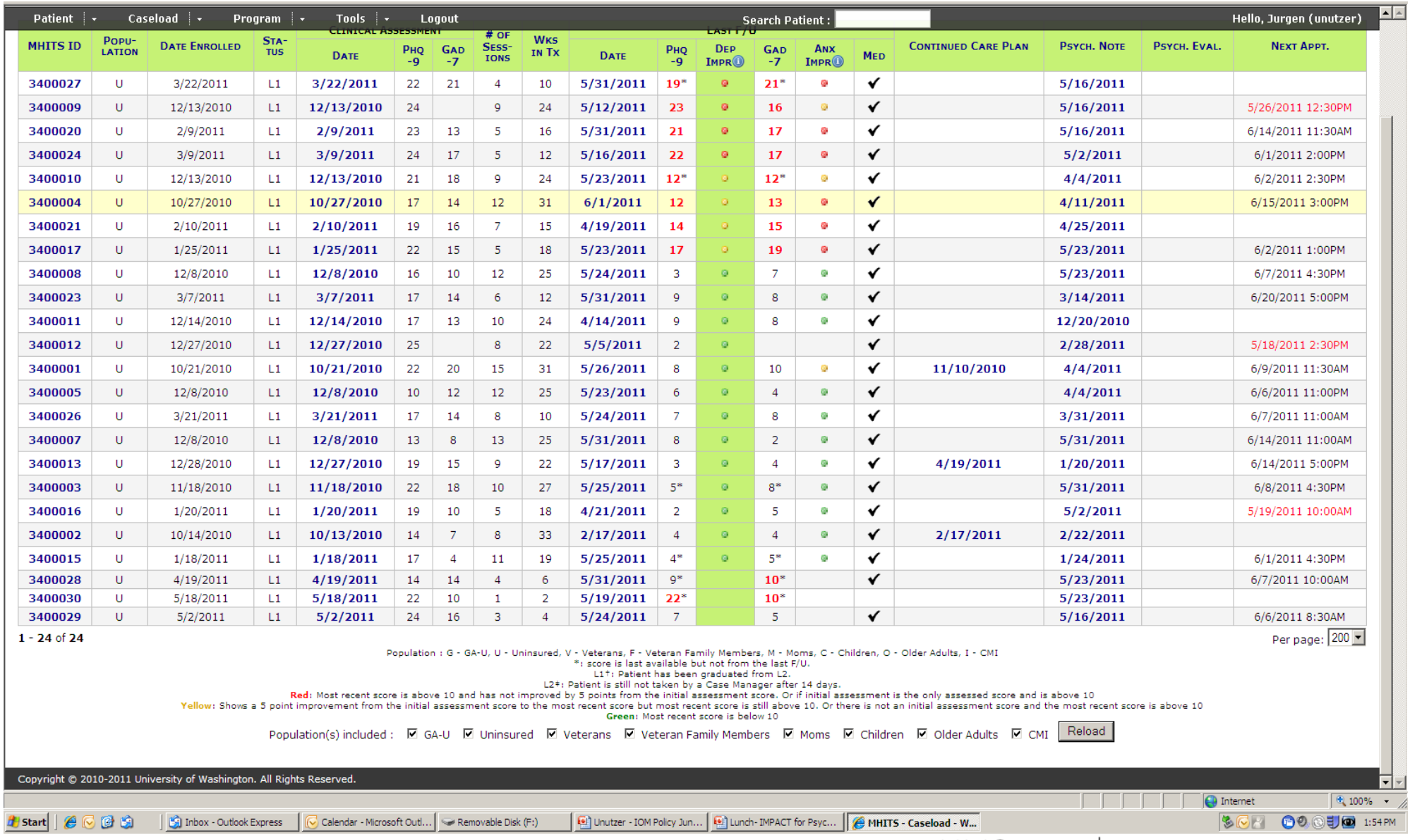
10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

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

Track Treatment Outcome Over Time



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
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3400011	U	12/14/2010	L1	12/14/2010	17	13	10	24	4/14/2011	9		8		✓		12/20/2010		
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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
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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
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3400003	U	11/18/2010	L1	11/18/2010	22	18	10	27	5/25/2011	5*		8*		✓		5/31/2011		6/8/2011 4:30PM
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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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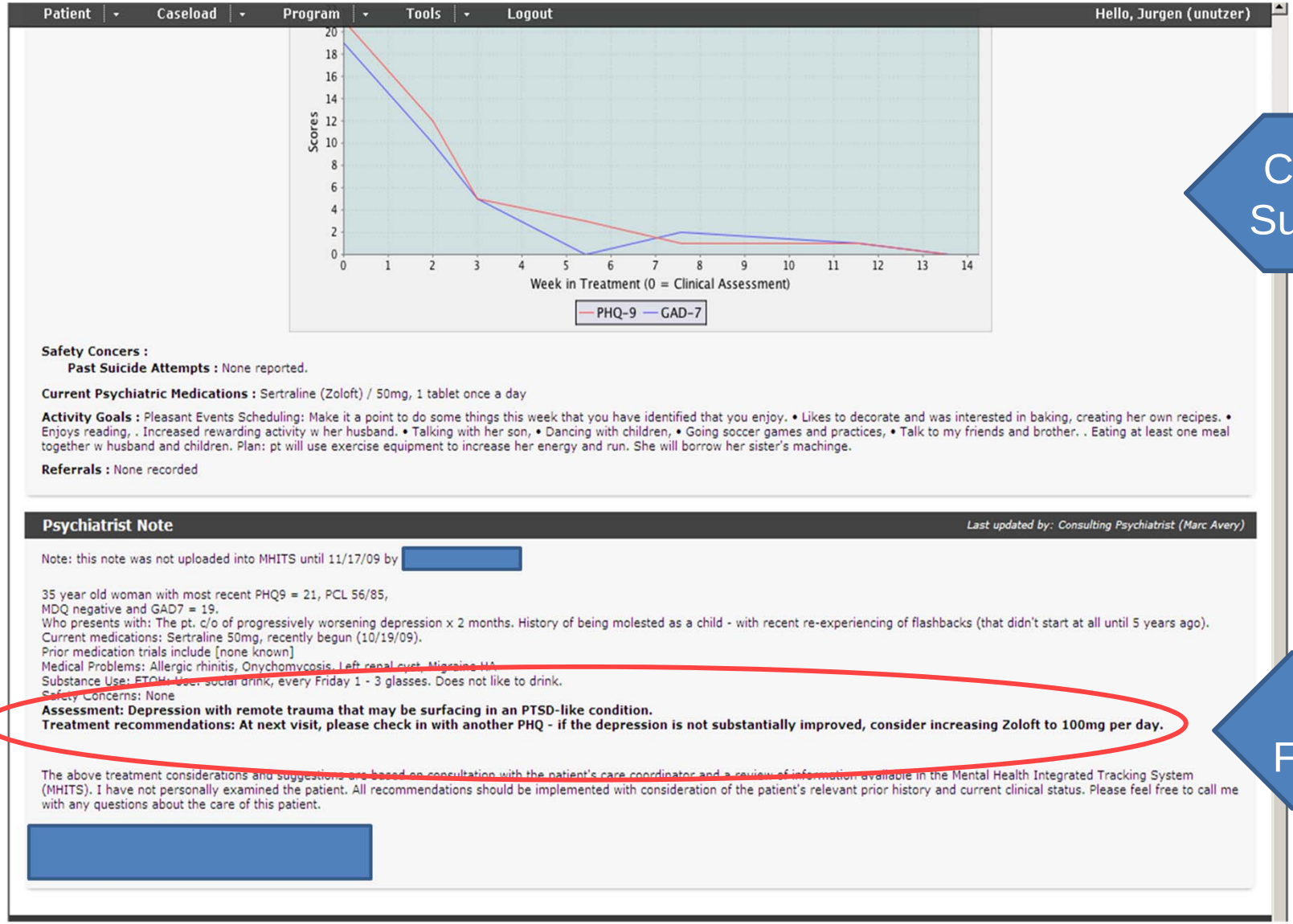
Internet 100% — Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... 1:54 PM

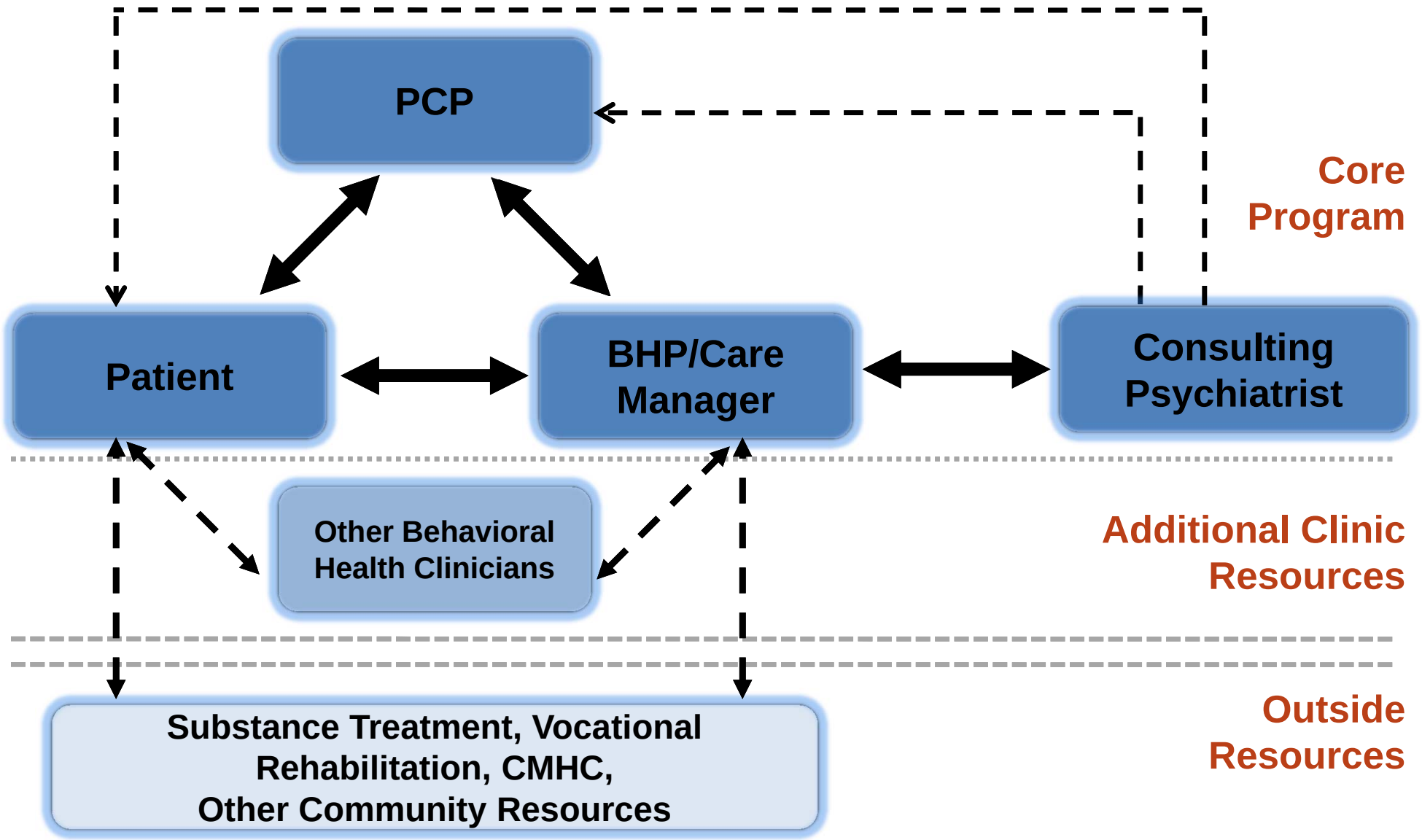
Example: Psychiatric Recommendations



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

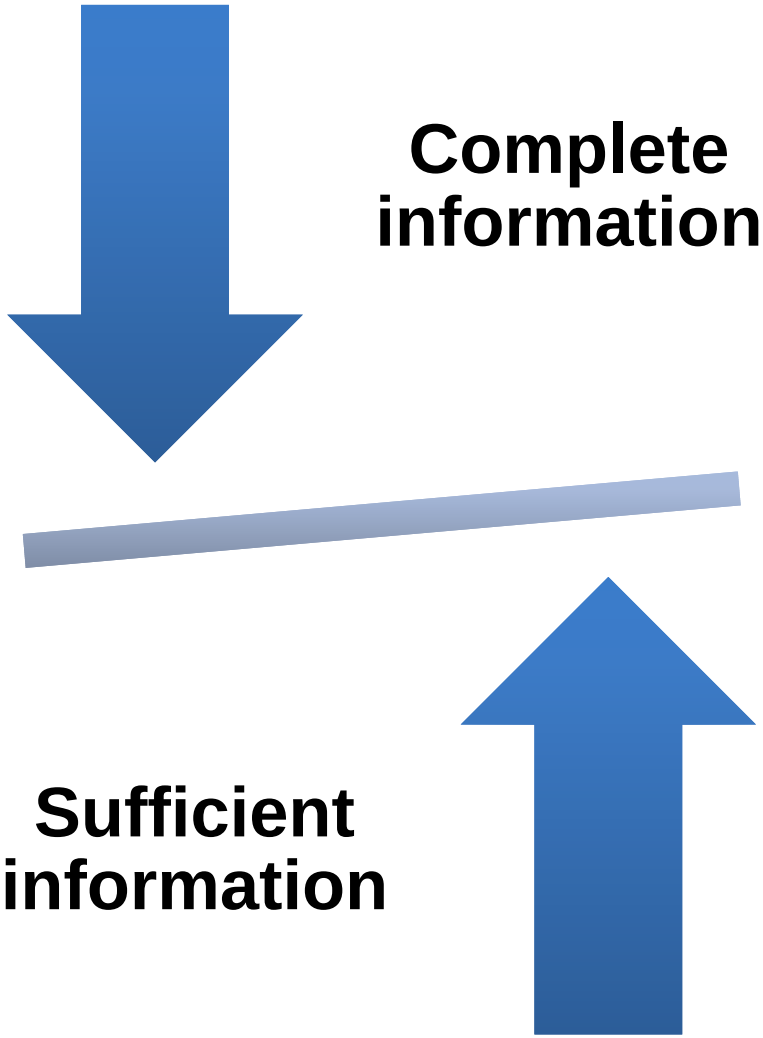
A Different Kind of Assessment: Shaping Over Time

Traditional Consult

One Session

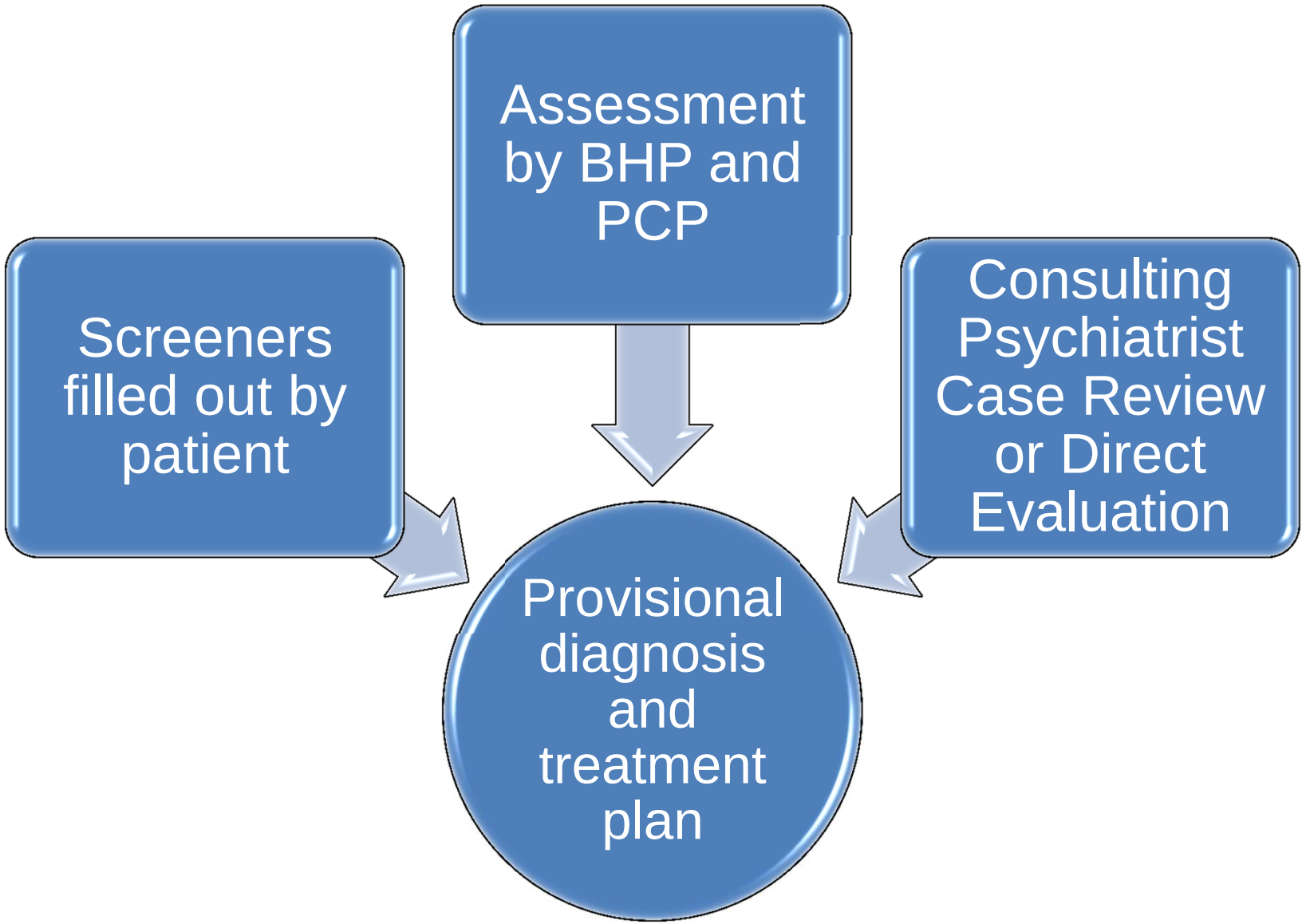
Integrated Care Consult

Uncertainty: Requests for More Information

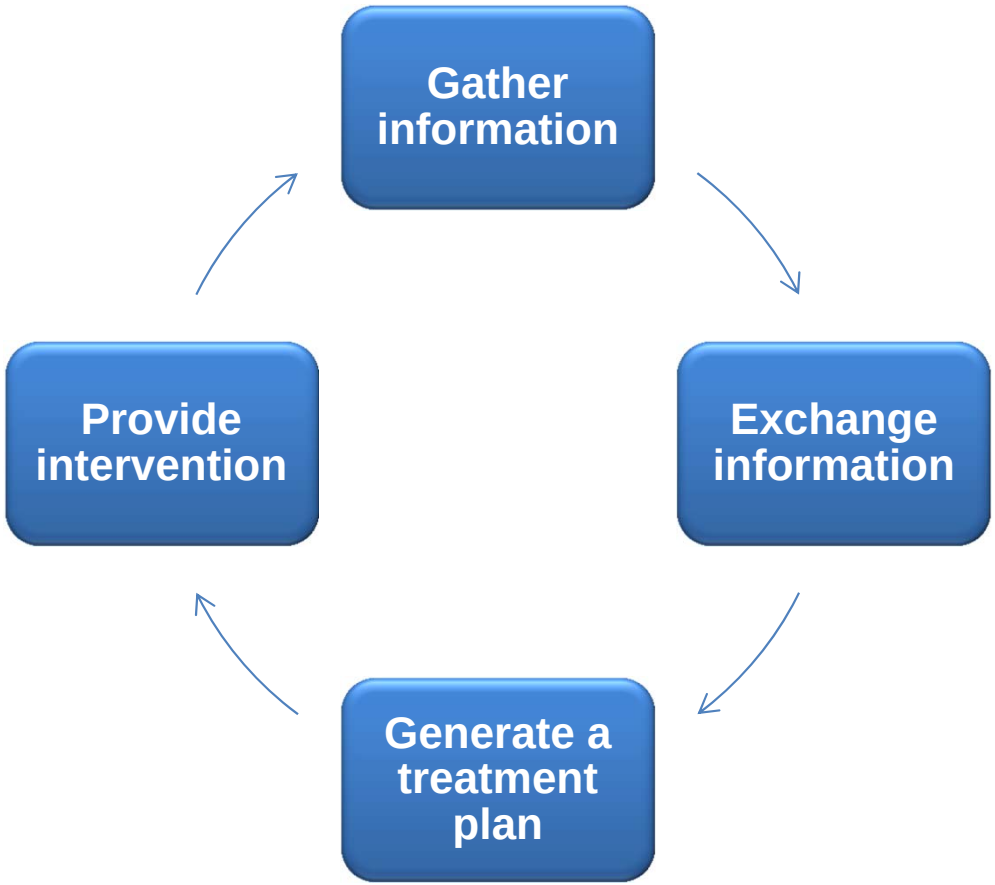


- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing

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

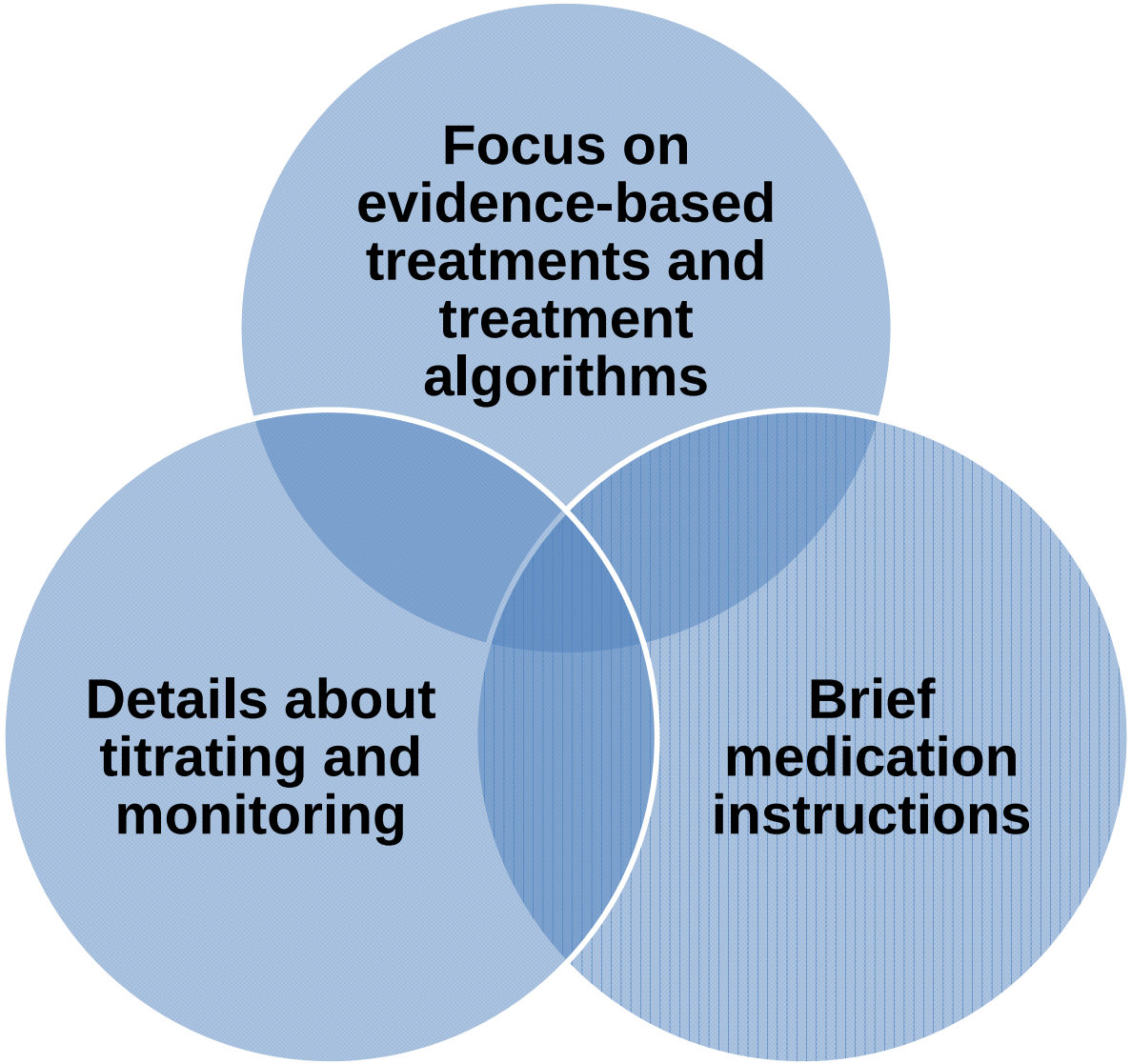
- Help differentiate crisis from distress
- Support development of treatment plans/team approach for patients with behavioral dyscontrol
- Support protocols to meet demands for opioids, benzodiazepines etc…
- Support the providers managing THEIR distress

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?

Recommendations: Pharmacological Treatment



Example: Medication Recommendation for Lithium

LITHIUM (LITHIUM CARBONATE), LITHIUM-CONTROLLED RELEASE (LITHIUM ER, LITHOBID)

DOSING INFORMATION: Initiation: Check baseline labs (urine pregnancy, basic metabolic panel (baseline BUN and Cr), CBC (for baseline WBC) TSH, EKG (for patients over 40 y/o). Week 1: 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, to increase tolerability). Week 2 and Beyond: Check lithium level weekly and as indicated increase dose in 300 mg/day increments to target plasma level of 0.8-1.0meq/L. Typical Target: Plasma level 0.8-1.0meq/L and less than 1.2meq/L which usually equates with daily dose of 1200mg to 1800mg. Dosing: Schedule should be determined by tolerability and compliance; Typically BID or QHS. Formulation: There are both immediate release and sustained release formulations. Nausea is more common with IR formulations and diarrhea with ER formulations.

***ONGOING MONITORING*:** Lithium: 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: Mechanism of action: 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. Pharmacokinetics: T ½ = ~24hrs. 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). Warnings and Precautions: The two most important long-term adverse effects of lithium involve the kidneys and thyroid gland. Cardiac rhythm disturbances have been described (these almost always occur in patients with preexisting cardiac disease). Contraindications: Known hypersensitivity reaction to the product. Significant renal impairment, significant cardiovascular disease, psoriasis, sodium depletion, dehydration, debilitation. Black Box Warning: (1) 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: Pregnancy: Category D; associated w/ increased risk of teratogenesis (need to inform women of childbearing age of this risk). Cardiac malformations, including Epstein'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), 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, and 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

"Beyond Medications"

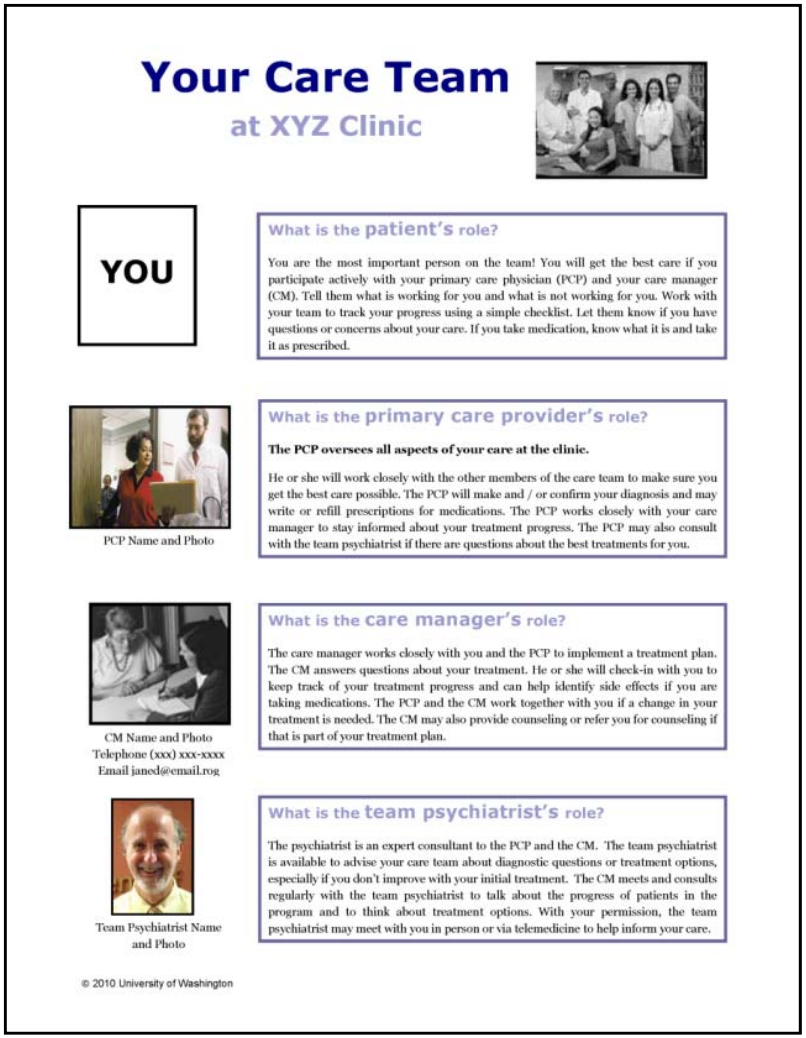
- Behavioral Medicine and Brief Psychotherapy
- Referrals and Community Resources
- Disability

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.

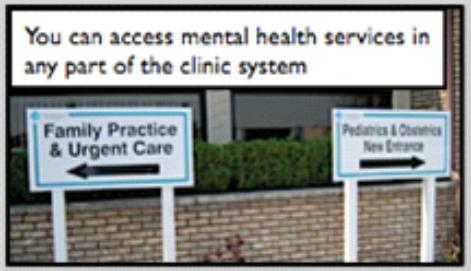
A Sample Program

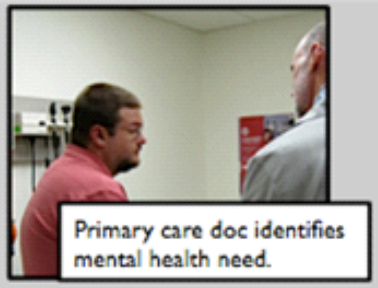
John Kern, MD

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.

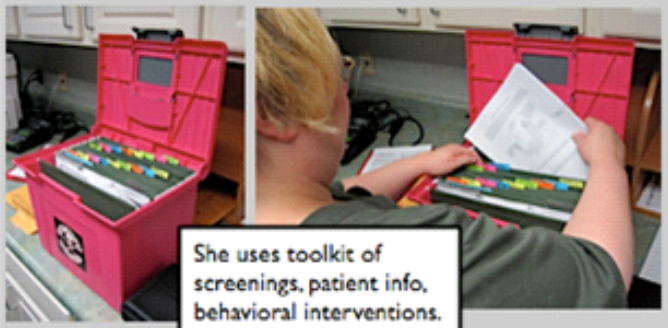
You can access mental health services in any part of the clinic system



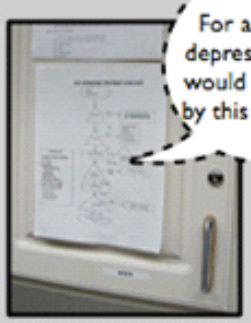


Primary care doc identifies mental health need.

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 !

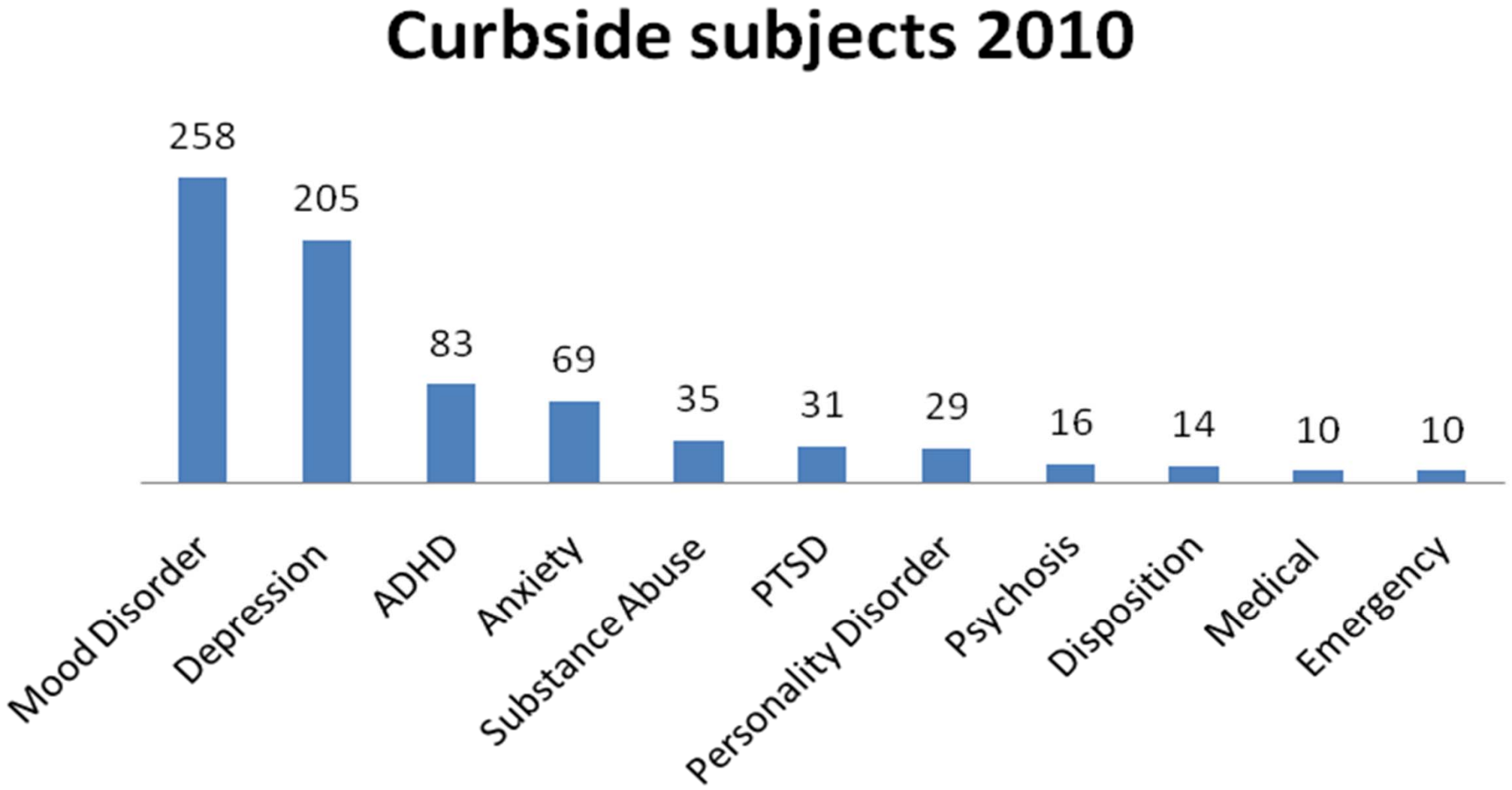
Sample Program: Psychiatrist Consultation

- 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.

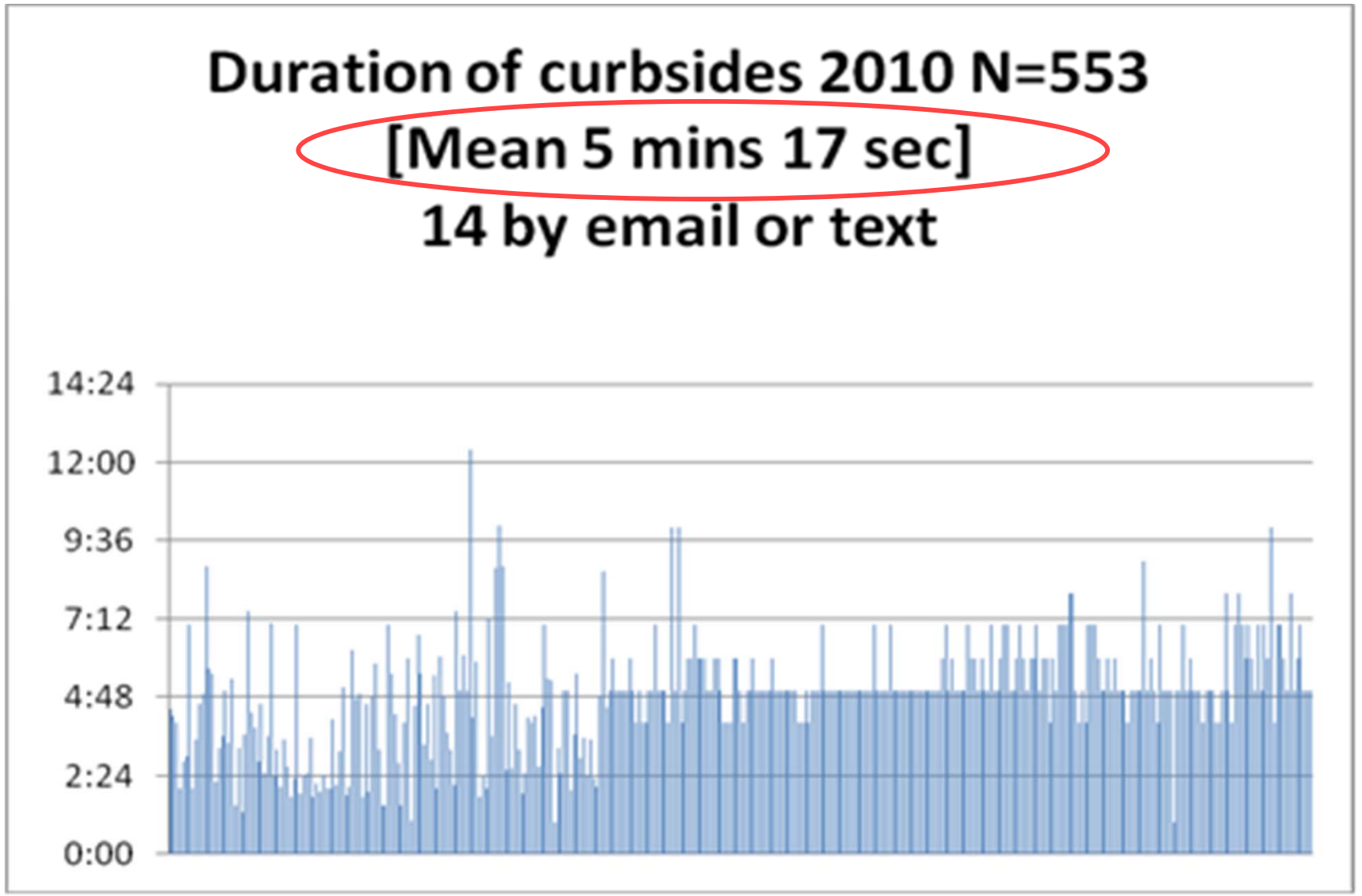
Sample Program: "Curbside" by Phone

- 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: 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.

The 'Business Case'

Payment

- Psychiatrist
  - Charges for time for consultation with care manager / PCPs (contracted time)
  - Bills for in-person consultations with patients → Lower no show rates because of increased access, shorter wait times, and support from care coordinator
- Care manager (e.g., LICSW) bills for in-person contacts using behavioral health or psychotherapy codes and / or charges 'case rate' payment to insurer

Additional Benefits

- Improve access for and satisfaction of patients
- Improve job satisfaction and productivity of PCPs → Shorter, more productive primary care visits
- Position organization for future
  - Long-term cost savings attractive to programs that aim to achieve the triple aim: improve access, quality and outcomes while containing costs.
  - Integrated Behavioral Health will be part of Patient Centered Medical Homes and ACOs

What About Liability for Collaborative Care?

PCPs

- The PCP oversees overall care of the patient and retains overall liability for care provided.
- PCP prescribes **all** medications
- Four elements of collaborative care should reduce risk:
  - Care manager supports the PCP
  - Use of evidence-based tools
  - Systematic, measurement-based follow-up
  - Psychiatric consultant

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.

What About Liability for Collaborative Care?

Psychiatric consultant

- 'Curbside consultation' that does not involve the direct patient assessment → limited liability (see Olick et al, Fam Med 2003).
- Direct consultation (either in-person or via telemedicine) → liable for the content of the assessment and treatment recommendations
- Should negotiate liability coverage as part of practice arrangement / contract

Be clear about scope of involvement

“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

‘Day in the life’ of a 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

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

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