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.

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**Primary Care is the ‘De Facto’ Mental Health System**

<table>
<thead>
<tr>
<th>Setting of Service</th>
<th>Provision of Behavioral Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Treatment</td>
<td>No Treatment</td>
</tr>
<tr>
<td>Treatment</td>
<td>Treatment</td>
</tr>
<tr>
<td>Physicians</td>
<td>Physicians</td>
</tr>
<tr>
<td>Physicians</td>
<td>Physicians</td>
</tr>
</tbody>
</table>

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

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**BUT**

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

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**Mental Disorders are Rarely the Only Health Problem**

- Chronic Physical Pain (25-50%)
- Cancer (10-20%)
- Neurologic Disorders (10-20%)
- Heart Disease (10-30%)
- Diabetes (10-30%)
- Smoking, Obesity, Physical Inactivity (40-70%)
- Mental Health / Substance Abuse (40-70%)

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**Bi-Directional Effects**

25 yr mortality gap in seriously mentally ill

- Depression = decreased medication adherence, smoking cessation, weight loss, or exercise
- Patients with depression have higher health care costs

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**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

Integrated Behavioral Health Care: we are ‘beyond the tipping point’.

Integrated Behavioral Health Care

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

Un-managed Care

Coordinated Care

- Fee for Service
- 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 Care

Health Care Reform:
Moving towards coordinated / integrated care.

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."
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 / week versus months
• Focusses in-person visits on the most challenging patients.

Regular Communication
• Psychiatrist has regular (weekly) meetins 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)

• 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 usual care as usual.
Doubles Effectiveness of Care for Depression

50% or greater improvement in depression at 12 months

Participating Organizations

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

Long-Term Cost Savings

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td>522</td>
<td>0</td>
<td>522</td>
<td>-210</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-94</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-96</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td>31,082</td>
<td>29,422</td>
<td>32,785</td>
<td>-3363</td>
</tr>
</tbody>
</table>

Unützer et al., Am J Managed Care 2008.

Better Physical Function

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

Usual Care

IMPACT

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

IMPACT Replication Studies

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

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

Endorsements for Collaborative Care

- IOM Report
- Presidents 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)
Collaborative Team Approach

Core Program
- PCP
- BHP/Care Manager
- Consulting Psychiatrist
- Patient
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources
- Additional Clinic Resources
- Outside Resources

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

MHIP Client Demographics

<table>
<thead>
<tr>
<th></th>
<th>Mean or %</th>
<th>Range across clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>52 %</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>48 %</td>
<td></td>
</tr>
<tr>
<td>Mean Age</td>
<td>40</td>
<td>1-100</td>
</tr>
<tr>
<td>Challenge with Housing</td>
<td>29 %</td>
<td>3% - 52 %</td>
</tr>
<tr>
<td>Challenge with Transportation</td>
<td>21 %</td>
<td>10% - 50 %</td>
</tr>
</tbody>
</table>

MHIP Co-Occurring Diagnoses

MHIP Common Client Diagnoses

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>71</td>
</tr>
<tr>
<td>Anxiety (GAD, Panic)</td>
<td>48</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>17</td>
</tr>
<tr>
<td>Alcohol / Substance Abuse</td>
<td>17</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15</td>
</tr>
<tr>
<td>Thoughts of Suicide</td>
<td>45</td>
</tr>
</tbody>
</table>

... plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ...
### MHIP Community Health Centers

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

Data from Mental Health Integrated Tracking System (MHITS)

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### MHIP: Evidence-Based Treatments

- 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](http://integratedcare-nw.org)

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### MHIP: Pay-for-performance-based quality improvement

Cuts median time to depression treatment response in half.

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### 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
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

<table>
<thead>
<tr>
<th>Time</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 AM - 12 PM</td>
<td>• Duties in a community mental health center or other clinical setting:</td>
</tr>
<tr>
<td></td>
<td>• Clinical and administrative</td>
</tr>
<tr>
<td></td>
<td>• Available for urgent curb-side consultations from primary care</td>
</tr>
<tr>
<td>12 PM - 1 PM</td>
<td>• Lunch: 30 min discussion of clinical topic with PCPs during provider meeting.</td>
</tr>
<tr>
<td>1 PM - 5 PM</td>
<td>• Duties as primary care consultant including:</td>
</tr>
<tr>
<td></td>
<td>• Work with BHP/Care managers</td>
</tr>
<tr>
<td></td>
<td>• Clinic visits and monthly integrated care team meeting for caseload review, QI, and strategic planning</td>
</tr>
</tbody>
</table>

‘Day in the life’ of a full-time primary care consulting psychiatrist

<table>
<thead>
<tr>
<th>Time</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 AM - 10 AM</td>
<td>• Systematic caseload-based review of patients who challenging or not improving  with care manager and recommendations to PCPs</td>
</tr>
<tr>
<td>10 AM – 12 PM</td>
<td>• Direct patient consultation / care (in person or via telemedicine)</td>
</tr>
<tr>
<td>12 PM - 1 PM</td>
<td>• Lunch: 30 min discussion of clinical topic with PCPs during provider meeting.</td>
</tr>
<tr>
<td>1 PM - 2 PM</td>
<td>• Return calls and questions from care managers and / or PCPs; curbside consultation with PCPs.</td>
</tr>
<tr>
<td>2 PM - 4 PM</td>
<td>• Direct patient consultation / care (in person or via telemedicine)</td>
</tr>
<tr>
<td>4 PM - 5 PM</td>
<td>• Monthly integrated care team meeting for caseload review, QI, and strategic planning</td>
</tr>
</tbody>
</table>

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

**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 and 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 MHIP care management handbook.

See [http://uwaims.org](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.
Module 1: Introduction to Primary Care Consultation Psychiatry

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.

**Resources to provide to your team:**

- **Information for PCPs from Washington State Integrated Care Program:** [http://integratedcare-nw.org](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](http://www.pcpcc.net)

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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

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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.icci.org/healthcare_redesign/diamond_35953/](http://www.icci.org/healthcare_redesign/diamond_35953/)

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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.

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Selected References
