Mental Health Care in Primary Care Settings
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The SAMHSA/HRSA Center for Integrated Health Solutions

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

Online: www.CenterforIntegratedHealthSolutions.org
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Email: Integration@thenationalcouncil.org

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

- 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

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

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

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

Ways to cope:
- Focus:
  - What is the most serious?
  - What is practical to accomplish today?
  - Diagnose and treat ‘over time’
- Get help
  - TEAMWORK

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

Health Care Reform: Moving towards coordinated / integrated care.

Coordinated Care: Accountable Care
- Fee for Service
  - Inpatient focus
  - OP clinic care
  - Low Reimbursement
  - Poor Access and Quality
  - Little oversight
- No organized networks
- Focus on paying claims
- Little Medical Management

Un-managed Care

Patient Centered
- 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

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
Practice Support
Informed, Active Patient
Measurement-based Stepped Care
Caseload-focused psychiatric consultation
Training

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</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>

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></td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-106</td>
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<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-714</td>
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<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</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>-58</td>
</tr>
<tr>
<td>Total health care cost</td>
<td>31,082</td>
<td>29,422</td>
<td>32,785</td>
<td>-3,363</td>
</tr>
</tbody>
</table>

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

Collaborative Team Approach

Overview - Mental Health in Primary Care Settings

Overview - Mental Health in Primary Care Settings
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 Integrated Care Team

MHIP: > 25,000 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
(6 clinics; over 2,000 clients served)

<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)

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)

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

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**

- **Better access**  
  - PCPs get input on patients' behavioral health problems within 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**

- **Core Program**  
  - PCP  
  - Patient  
  - BHP/Care Manager  
  - Consulting Psychiatrist  
  - Other Behavioral Health Clinicians

- **Additional Clinic Resources**  
  - Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

- **Outside Resources**

**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

**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
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

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

Your Offer
“I’m here for you.”
“I’ve got your back.”
Overview - Mental Health in Primary Care Settings

Other Behavioral Health Clinicians

Consulting Psychiatrist

Roles of the Primary Care Consulting Psychiatrist

Leading the Development of an Integrated Care Program

Consulting Psychiatrist Leadership
Overview - Mental Health in Primary Care Settings

Team Building Process

Define Scope and Tasks

Assess current resources and workflow

Define team member responsibilities and integrated workflows

Assess hiring and training needs

Integrated Care: Core Components and Tasks

Patient Identification and Diagnosis

Engagement in Integrated Care Program

Evidence Based Treatment

Systematic Follow-up, Treatment Adjustment, Relapse Prevention

Communication, Care coordination and Referrals

Systematic Case Review and Psychiatric Consultation

Program Oversight and Quality Improvement

“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

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’

<table>
<thead>
<tr>
<th>Medical Specialty</th>
<th>‘Problem Patients’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedics</td>
<td>Low back pain</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>Pelvic pain, PMS</td>
</tr>
<tr>
<td>ENT</td>
<td>Tinnitus</td>
</tr>
<tr>
<td>Neurology</td>
<td>Dizziness, headache</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Atypical chest pain</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Hyperventilation, dyspnea</td>
</tr>
<tr>
<td>Dentistry</td>
<td>TMJ syndrome</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Chronic Fatigue Syndrome</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Closed head injury</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Hypoglycemia</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>Multiple chemical sensitivity</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Mood Disorders</th>
<th>Anxiety Disorders</th>
<th>Psychotic Disorders</th>
<th>Substance Use Disorders</th>
<th>Cognitive Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9: Depression</td>
<td>GAD-7: Anxiety, GAD</td>
<td>Brief Psychiatric Rating Scale</td>
<td>CAGE-AID</td>
<td>Brief &amp; Focused</td>
</tr>
<tr>
<td>MDQ: Bipolar disorder</td>
<td>PCL-C: PTSD</td>
<td>Positive and Negative Syndrome Scale</td>
<td>AUDIT</td>
<td>Concise</td>
</tr>
<tr>
<td>CIDI: Bipolar disorder</td>
<td>OCD: Young-Brown</td>
<td>Social Phobia Mini-social phobia</td>
<td>Montreal Cognitive Assessment</td>
<td>Summary</td>
</tr>
</tbody>
</table>

Caseload Summary: Prioritizing Cases to Review

Example: Psychiatric Recommendations
Collaborative Team Approach

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

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
- Visit 1: January
  - Pt still has high PHQ
- Visit 2: March
  - Side effects
- Visit 3 - Pt improved!

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 by BHP and PCP
- Consulting Psychiatrist Case Review or Direct Evaluation
- Provisional diagnosis and treatment plan
- Screeners filled out by patient
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’

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 for managing difficult patients

Example: Medication Recommendation for Lithium

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: Pharmacological Treatment

Recommendations: Other Interventions

“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

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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.

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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.

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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

\[ \text{Total: } 15.8 \]

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

<table>
<thead>
<tr>
<th>Curbside subjects 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>ADHD</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Substance Abuse</td>
</tr>
<tr>
<td>PTSD</td>
</tr>
<tr>
<td>Personality Disorder</td>
</tr>
<tr>
<td>Psychosis</td>
</tr>
<tr>
<td>Disposition</td>
</tr>
<tr>
<td>Medical</td>
</tr>
<tr>
<td>Emergency</td>
</tr>
</tbody>
</table>

Sample Program: Curbside Consultation Duration

Duration of curbsides 2010 N=553

[Mean 5 mins 17 sec]
14 by email or text

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.

**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 about the care of this patient.”

Dr. x, Consulting Psychiatrist
Phone #.
Pager #.
E-mail

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

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</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 – 12PM:</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>2PM - 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>

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

Selected References

Selected References


Brief Behavioral Interventions

References - I

Motivational Interviewing:


Distress Tolerance:

• Linehan M. Skills Training Manual for Treating Borderline Personality Disorder Guilford Press, 1993

Behavioral Activation:


References - II

Problem Solving Therapy:


Disability:


Special Populations References

Medical Co-morbidity:


Pregnancy and Lactation:


• MGH Center for Women's Mental Health http://www.womensmentalhealth.org/

Older Adults:
