Best Practices in Psychiatric Consultation

NYS Collaborative Care Medicaid Program

January 4th, 2016
Presentation topics

- Depression problem overview
- Collaborative care model
- Role of psychiatric consultant
- Role of care manager
- Interaction of psychiatric consultant with care manager and PCP
- Consultation documentation
- Liability
- Registry/metrics
- Challenges
Speakers

Abigail Herron, DO, The Institute for Family Health

Jacob Samander, MD, Open Door Family Medical Center

Laura Leone, LMSW, The Institute for Family Health
Upcoming case calls

**Group 1:**
Friday January 22nd 2016, 9:30am-11am

**Outpatient/community clinics:** Open Door, CHN, Highland Hospital, Niagara Falls, SUNY, Anthony Jordan, Highland Hospital, Belvis, Cumberland, East NY, Morrisania

**Group 2:**
Thursday February 4th 2016, 1:00-2:30pm

**Hospitals:** Mt. Sinai, NYP, Montefiore, Harlem Hospital, Bellevue, Coney Island, Elmhurst, Kings, Metropolitan, Queens, Woodhull, NCB, Jacobi, Lincoln, East NY, Gouverneur, Renaissance
The Institute for Family Health
Abigail Herron, DO
Director of Psychiatry
Depression is a Chronic Disease

15 years after recovery, *85% of patients have experienced a recurrence\textsuperscript{1,2}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart.png}
\caption{Cumulative Probability of Recurrence}
\end{figure}
Depression negatively affects health & well being...

- ↑ medical morbidity, mortality, and disability
- ↑ suicide risk
- ↑ tobacco, alcohol, and/or drug use
- ↑ risk of MI, CVA, DM
- ↑ healthcare utilization
- ↓ adherence to treatments (medical and psychiatric)
- ↓ function (home and work)
Depression is under-diagnosed and under-treated
Over 25 FDA-approved antidepressant medications and other treatments:

• Almost 10% of the US population are taking antidepressants

• According to the AHRQ = 170 million prescriptions filled for antidepressants in 2005

• 70% are prescribed by non-psychiatrists (general practitioners, family practitioners and internal medicine specialists)
Depression is under-diagnosed and under-treated

BUT: fewer than 50% are effectively treated

- Local perspective: 2004 NYC HANES = 8% of NYers had a diagnosis of depression at time of survey but only 37% were receiving clinically appropriate treatment.

- Depressed patients visit their primary care provider 3xs more often than patients who are not depressed.
Depression is under-diagnosed and under-treated

- Nearly $\frac{1}{3}$ of antidepressant prescriptions are never filled.
- Nearly $\frac{1}{2}$ of patients discontinue pharmacotherapy during the first month.
- Over 30 – 50% of patients will have a complete response to initial treatment.
- 50 – 70% will require at least one change in treatment to get better.
Availability of Psychiatric Care

• Despite increases in the number of graduates entering the field of psychiatry over the past ten years, the current psychiatric workforce is not sufficient to meet the needs of patients.
• Integration of primary and behavioral healthcare provides opportunities for psychiatrists interested in reaching a greater population of patients with their skills and expertise and provides patients with increased access to care.
Principles of Collaborative Care

• Patient-Centered Team Care
• Population-Based Care
• Measurement-Based Treatment to Target
• Evidence-Based Care
• Accountable Care
Role of Psychiatric Consultant

• Supports care managers and PCPs
• Provides regular (weekly) and as needed consultation on a caseload of patients followed in primary care
  – Focus on patients who are not improving clinically
• In person or telemedicine consultation or referral for complex patients
• Provides education and training for primary care-based providers
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
Interaction between consultant & care manager

• Elements of effective caseload consultation
  – Regularly scheduled meeting times
  – Structured caseload review
  – Access to accurate and reliable clinical information
  – Effective documentation and communication of recommendations
Interaction between consultant & care manager

• Preparation for consultation meetings
  – Prioritize patients for review
  – Be prepared
    • Consider creating a template with relevant information
      – Identifying Information
      – Suicidality
      – Current Behavioral Health Conditions including Substance use
      – Behavioral Health History
      – Psychosocial Factors
      – Medical Conditions
      – Current Treatment
      – Goals & Questions

* Template available on the AIMS Center website: http://aims.uw.edu/
Relevant Information for Consultation

Case Review: Care Manager with Psychiatric Consultant

Brief ID: Name, Age, Gender

Suicidality
- Endorsed?
- Passive (without plan or intent), active (with plan but no intent), or active with a plan and intent? If active, how imminent is safety threat and is there a safety plan in effect?
- Has the patient previously attempted suicide? If so, by what method?

Current Behavioral Health Conditions and Symptoms
- What are current behavioral health conditions and their severity? Use scores from symptom measures.
- How are symptoms affecting functioning? Which symptoms are most problematic for patient?
- If anxiety: GAD, PTSD, OCD, panic, or social anxiety disorder?
- If PTSD: is patient experiencing nightmares on a regular basis and what is the cause(s) of PTSD?
- If psychosis: Are hallucinations present? If yes, are there command hallucinations? Are delusions present? If yes, what kind of delusions (e.g., paranoid vs. grandiose)?
- If mood: Depression? Bipolar? Utilizing either the MDQ or CIDI-3 bipolar screeners and always inquiring (1) about a family history of bipolar disorder or schizophrenia and (2) if the patient has previously been diagnosed with bipolar disorder. If bipolar screen is positive, the following follow-up questions are essential to ask:
  - How often do the potential hypomanic/manic episodes occur?
  - How long do the potential hypomanic/manic episodes last? hours, days, or weeks?
  - Do the potential hypomanic/manic episodes only occur in the context of substance abuse?
- If substance use: Current use? Past use? Drug of choice? Previous CD treatment? Ongoing relapse prevention (e.g., AA or NA)?
- Other conditions: Cognitive Disorder? Dementia? Head Injury? ADHD? Eating Disorder? Personality Disorder?

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Relevant Information for Consultation

Case Review: Care Manager with Psychiatric Consultant

History of Behavioral Health Conditions
- History of behavioral health problems
- History of behavioral health treatment and effectiveness of treatment
  - Medications: Type? Dosage? Efficacy? Side effects?
  - Psychotherapy: Type? Duration? Efficacy?

Psychosocial factors
- Is the patient homeless or does the patient have stable housing?
- Is the patient’s support system limited, poor, fair, or good?
- Is the patient a victim of abuse growing up or domestic violence as an adult?
- Does the patient have a legal (e.g., felony) history?

Medical Problems
- Pain?
- Body Mass Index (BMI)?
- Endocrine problems: Thyroid disease? Diabetes?
- Hypertension?
- Seizure disorder?
- Pregnant or breastfeeding?

Current Treatment
- Medication? If yes: type, dose, efficacy, side effects
- Psychotherapy
- Other therapeutic interventions (including referrals)

Goals & Questions
- Patient
- Team
Documentation of Consultation

• Recommendations should be brief and focused to increase likelihood of implementation

• Recommendations can include requests for further information as well as specific treatment recommendations

• Short concise summary of information used in decision-making as well as focused recommendations
Medication Recommendations

- Focus on evidence-based treatments and treatment algorithms
- Brief medication instructions
- Details about titrating and monitoring
Recommendations for Other Interventions

• Support Managing Difficult Patients
  – Working with demanding patients
  – Protocols for managing suicidal ideation
  – Working with patients with chronic pain

• Beyond Medication
  – Psychotherapy
  – Referrals and Community Resources
Communication with PCP

• In most cases, the review and recommendations are provided through a care manager supporting the PCP but in some cases, the communication is directly between the PCP and the consulting psychiatrist

• The psychiatric consultant does not typically see the patient for a face-to-face assessment and instead relies on information provided by the care manager and/or PCP
Communication with PCP

• The psychiatric consultant should help to prepare the care manager to communicate recommendations to the PCP

• May be useful to develop a template for communication with the care manager to aid in this process
Sample Template for Communicating with PCP

- **ID**
- **Baseline Clinical Measures (i.e. PHQ-9)**
- **Current Measures & Symptoms**
- **Treatments**
  - Current treatments & duration
  - Previous treatments
- **Side Effects to current treatment**
- **Other Information (if relevant to PCP)**
  - Suicidality
  - Relevant Medical History
  - Potential medication interactions
  - Substance Use
- **Action Items**
  - Recommendations from psychiatrist
  - Medication changes
Psychiatric Consultant-Educator

• Discussion of recommendations with PCP
• Responding to urgent or emergent requests from PCPs
• Attending primary care provider meetings
• Responding to “curb-side” requests
Psychiatric Consultant-Educator

• Care manager learns from Psychiatric Consultant
  – Psychiatric diagnosis and formulation
  – Psychotropic medications
  – Impact of medical illness

• Psychiatric Consultant learns from Care Manager
  – Real life impacts of psychiatric illness
  – Day-to-day culture of primary care
  – Availability of community services
  – Particulars of mental health coverage
Liability

• Typically, PCP makes diagnosis, prescribes all medications and assumes all liability

• Psychiatrist usually does not see patient and should be clear in their documentation about the limited role played as consultant
  
  – Visit AIMS Center website for a Source Document on Risk Management and Liability Issues in Integrated Care Models

• Consider including disclaimer statement in documentation
Sample Disclaimer

• “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. 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.”
Summary

• Collaborative Care offers an evidence-based modality for integrated treatment of behavioral and medical health conditions

• The psychiatric consultant provides support and recommendations to treatment team through regular caseload supervision

• The consultant also functions as an educator to the treatment team
Questions?
Open Door Family Medical Centers
Jacob Samander, M.D.
Psychiatry
Demographics

- 45,000 patients seen at Open Door
- Primarily Monolingual in Spanish
- 130 patients enrolled in OMH (108 active and 22 non-active)
- 11 Care Managers/LCSW Therapists
- 4 Care Managers
- 1 Data Manager
Overview

• Psychiatry serves as clinical support and back-up to primary care as initiator and treater of BH DX

• Create multiple and direct ways to communicate between PCP and Psychiatrist
Need for Collaborative Care

• Deficit in Psychiatry in USA
  – “Another [strategy] is to promote greater use of collaborative care, where psychiatrists provide greater consultation to general practitioners. Along these lines, there are also calls for primary care physicians to have more mental health training.” – Psychiatry Adviser September 08, 2015

• Roughly 40,000 Psychiatrists in USA
  – 200,000 Primary Care Physicians
# Environment for Collaborative Care

## Annual Per Person Cost of Care

**Common Chronic Medical Illnesses with Comorbid Mental Condition**

"Value Opportunities"

<table>
<thead>
<tr>
<th>Patient Groups</th>
<th>Annual Cost of Care</th>
<th>Illness Prevalence</th>
<th>% with Comorbid Mental Condition*</th>
<th>Annual Cost with Mental Condition</th>
<th>% Increase with Mental Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Insured</td>
<td>$2,920</td>
<td></td>
<td>10%-15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>$5,220</td>
<td>6.6%</td>
<td>36%</td>
<td>$10,710</td>
<td>94%</td>
</tr>
<tr>
<td>Asthma</td>
<td>$3,730</td>
<td>5.9%</td>
<td>35%</td>
<td>$10,030</td>
<td>169%</td>
</tr>
<tr>
<td>Cancer</td>
<td>$11,650</td>
<td>4.3%</td>
<td>37%</td>
<td>$18,870</td>
<td>62%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$5,480</td>
<td>8.9%</td>
<td>30%</td>
<td>$12,280</td>
<td>124%</td>
</tr>
<tr>
<td>CHF</td>
<td>$9,770</td>
<td>1.3%</td>
<td>40%</td>
<td>$17,200</td>
<td>76%</td>
</tr>
<tr>
<td>Migraine</td>
<td>$4,340</td>
<td>8.2%</td>
<td>43%</td>
<td>$10,810</td>
<td>149%</td>
</tr>
<tr>
<td>COPD</td>
<td>$3,840</td>
<td>8.2%</td>
<td>38%</td>
<td>$10,980</td>
<td>186%</td>
</tr>
</tbody>
</table>

*Cartesian Solutions, Inc.™—consolidated health plan claims data

**Melek S et al APA 2013
www.psych.org

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Support for Delivering Collaborative Care

• EDUCATION
  – NEW GRAD TO “SEASONED” PROVIDER

• COMMUNICATION

• DOCUMENTATION

• ACCESSABILITY
  – SUPPORT FOR PROVIDERS
  – MORE IMMEDIATE ACCESS TO PSYCHIATRY

• TEAM ENVIRONMENT
OMH Project Workflow

- The psychiatrist has multiple touch points and venues in which to communicate with the care manager/therapist around patient progress/care
  - Weekly supervision
  - Weekly case review meeting
  - Weekly clinical workforce development meeting (training with case presentations)
• Psychiatrist makes recommendations for treatment adjustment to CM/LCSW
  – Therapist documents consultation communication in patient record
  – Therapist communicates to PCP the current symptoms of patient and progress or lack thereof

• PCP at that point will initiate medication, make medication adjustments or request psychiatric consultation
• If Psychiatrist recommends a psychiatric evaluation after reviewing patient chart
  • Psychiatrist will evaluate patient to resolve any diagnostic dilemmas and suggest treatment recommendations to PCP
  • - OR - Psychiatrist will treat to stabilize and return patient to continue care plan with PCP
CMTS

- Weekly metrics are distributed to CM/LCSW
  - Metrics are discussed in weekly team meeting
- Metrics are distributed to PCP weekly and reviewed
Barriers

• Adjustments were made with the communication loop between Care manager/LCSW therapist and PCP
  – LCSWs were coached in using PCP friendly language to better communicate the needs of patient
  – PCP feedback that they understand better how they can intervene on patient behalf
Questions?
The Institute for Family Health
Laura Leone, LMSW
Regional Director
Care Manager Role

- Commonly LMSW, LCSW, MA/MS Counselor, LMFT
- Some Collaborative Care sites choose to divide the CM role among two staff: a licensed professional who can provide treatment and a paraprofessional to help with care coordination and engagement.
- Builds in-house capacity to combat loss of patients referred to specialty care by PCP (~50% do not follow through on referral)
- Supports and collaborates closely with PCPs managing patients in primary care
Care Manager Role (cont.)

• Facilitates patient engagement and education
• Performs initial and follow-up assessments
• Systematically tracks treatment response
• Supports medication management by PCPs
• Provides brief, evidence-based therapeutic interventions (e.g. behavioral activation)
• Typical interventions provided by the CM: Problem Solving Treatment, Behavioral Activation for Depression, Motivational Interviewing or refers patient for counseling services
Care Manager Role (cont.)

• Provides “watchful waiting” to those not receiving a therapeutic intervention
• Reviews cases with psychiatric consultant weekly
• Facilitates referrals to other services as needed (e.g. substance abuse)
• Creates shared care plan / treatment plan in collaboration with patient and PCP
• Creates relapse prevention plan with patient
Comparison of Contacts in Usual Care vs. Collaborative Care

**USUAL CARE**

3.5 PCP Contacts per year

20% - 40% treatment response/improvement

Based on HRSA report of average PCP visit rates for FQHCs
Comparison of Contacts in Usual Care vs. Collaborative Care

Collaborative CARE

- 3.5 PCP Contacts per year
- 10 contacts with CM (on average)
- 2 case consultations from psychiatrist to CM/PCP (on average)

50% - 70% treatment response/improvement
Follow-Up Contacts

• “Eyes and ears” between PCP appointments
• Weekly or every other week during acute treatment phase
  – In person or by telephone to evaluate symptom severity (PHQ-9, GAD-7) and treatment response
• Initial focus on
  – Adherence to medications
  – Side effects
  – Follow-up on activation and PST plans
• Later focus on
  – Complete resolution of symptoms and restoration of functioning
  – Long-term treatment adherence
Tracking Clinical Outcomes

• Prevent people from ‘falling through the cracks’
• Facilitate treatment planning and adjustment
  – Combat ‘clinical inertia’: patients staying on ineffective treatments for too long
• Know when it is time to get consultation / get help and when it is time to change treatment
Tracking Clinical Outcomes (cont.)

• 50% reduction from baseline PHQ-9 OR a drop from baseline PHQ-9 of at least 5 points and to less than 10

• Among those enrolled in treatment for 70 days or greater who did not improve, the CM should review case with the Consulting Psychiatrist, with treatment recommendations provided to the Primary Care Provider
Depression Registry

• Updated weekly
• Located on a shared drive/folder
• Managers/supervisors should have access
• Includes patients’ PHQ-9 scores and other information relevant to their depression care
## Depression Registry

<table>
<thead>
<tr>
<th>First PHQ9 Date in Initial 90 Days</th>
<th>Last Phq9 Dept</th>
</tr>
</thead>
<tbody>
<tr>
<td>First PHQ9 Value in Initial 90 Days</td>
<td>Last Phq9 Prov</td>
</tr>
<tr>
<td>First PHQ9 Dept in Initial 90 Days</td>
<td>Change Value In 90 Days Prior To Last</td>
</tr>
<tr>
<td>First PHQ9 Prov in Initial 90 Days</td>
<td>Change Percent In 90 Days Prior To Last</td>
</tr>
<tr>
<td>Last Phq9 Date in Initial 90 Days</td>
<td>Standard Met In 90 Days Prior To Last</td>
</tr>
<tr>
<td>Last Phq9 Value In Initial 90 Days</td>
<td>Depression On PI</td>
</tr>
<tr>
<td>Last Phq9 Dept In Initial 90 Days</td>
<td>Depression On PI Dx</td>
</tr>
<tr>
<td>Last Phq9 Prov In Initial 90 Days</td>
<td>Depression Enc In Past Year</td>
</tr>
<tr>
<td>Change Value In Initial 90 Days</td>
<td>Depression Enc In Past Year Dx</td>
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<tr>
<td>Change Percent In Initial 90 Days</td>
<td>Last Question 9 Positive</td>
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<tr>
<td>Standard Met In Initial 90 Days</td>
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<tr>
<td>First Phq9 Date In 90 Days Prior To Last</td>
<td>Last Suicide Risk Assessment Date</td>
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<tr>
<td>First Phq9 Value In 90 Days Prior To Last</td>
<td>Last Suicide Risk Assessment Dept</td>
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<td>First Phq9 Dept In 90 Days Prior To Last</td>
<td>Last Suicide Risk Assessment Prov</td>
</tr>
<tr>
<td>First Phq9 Prov In 90 Days Prior To Last</td>
<td>Last Safety Plan Date</td>
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<tr>
<td>Last Phq9 Date</td>
<td>Last Safety Plan Dept</td>
</tr>
<tr>
<td>Last Phq9 Value</td>
<td>Last Safety Plan Prov</td>
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<tr>
<td>Last Phq9 Dept</td>
<td>Antidepressants</td>
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</table>
Another example of a registry: CMTS

<table>
<thead>
<tr>
<th>Active Patients</th>
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<td>0000049</td>
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</tbody>
</table>
Depression Performance Metrics

• Summarizes the progress of individual providers’ patients

• Generated by the managers and given to staff on a quarterly basis

• Should be summarized and included in annual performance evaluations
Questions?