Session # F7

The Many Faces of Psychiatry in Primary Care Settings

- Patty Gibson, MD, CMO, Alleviant Health Systems
- Tom Salter, MD, Psychiatrist, Integrated Behavioral Health, Mayo Clinic
- Mark Williams, MD, Associate Professor, Mayo Clinic
- Lori Raney, MD, Principle, Health Management Associates

CFHA Annual Conference
October 17-19, 2019 • Denver, Colorado

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

- The presenters of this session currently have or have had the following relevant financial relationships (in any amount) during the past 12 months.

- Mark Williams, MD
  - HealthStat – advisory board member on models of mental health care for employees – honorarium
  - Neuroscience Educational Institute – peer review of presentations on psychopharmacology
- Lori Raney, MD- royalties from APPI for books published on Integrated Care
- Patty Gibson, MD - none
- Tom Salter, MD - none

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Describe 3 ways to leverage psychiatric expertise in the primary care setting
- Understand the role of measurement and stepped care in improving patient outcomes
- Describe ways to employ psychiatric providers to raise capacity of the primary care team

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Bibliography / Reference

1. Fortney, Unutzer et al: The Tipping Point for MBC in Behavioral Health; Psych Services 2016.
2. Raney, Lasky, Scott: Integrated Care: A Guide for Effective Implementation: Role of the Psychiatric Consultant. 2017.
3. Katzelnick DJ, Williams MD: Large-Scale Dissemination of Collaborative Care and Implications for Psychiatry. Psychiatric services 2015, 66(9):904-906.
4. Carlo AD, Unutzer J, Ratzliff ADH, Cerimele JM, Financing for Collaborative Care – A Narrative Review. Curr Treat Options Psychiatry. 2018.
5. Kroenke, K, Unutzer, J: Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services Into Primary Care. JGIM 2017.

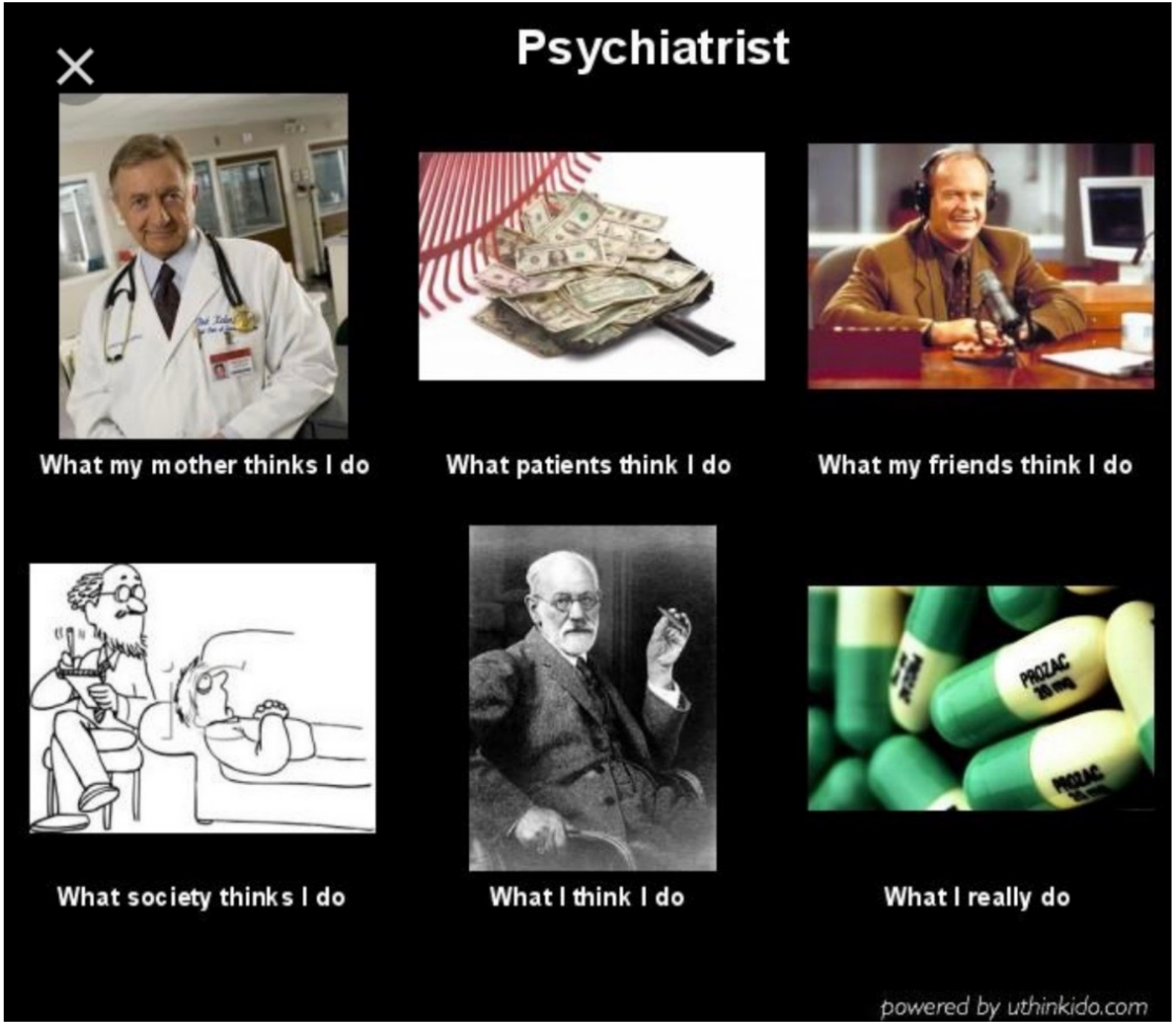
CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Learning Assessment

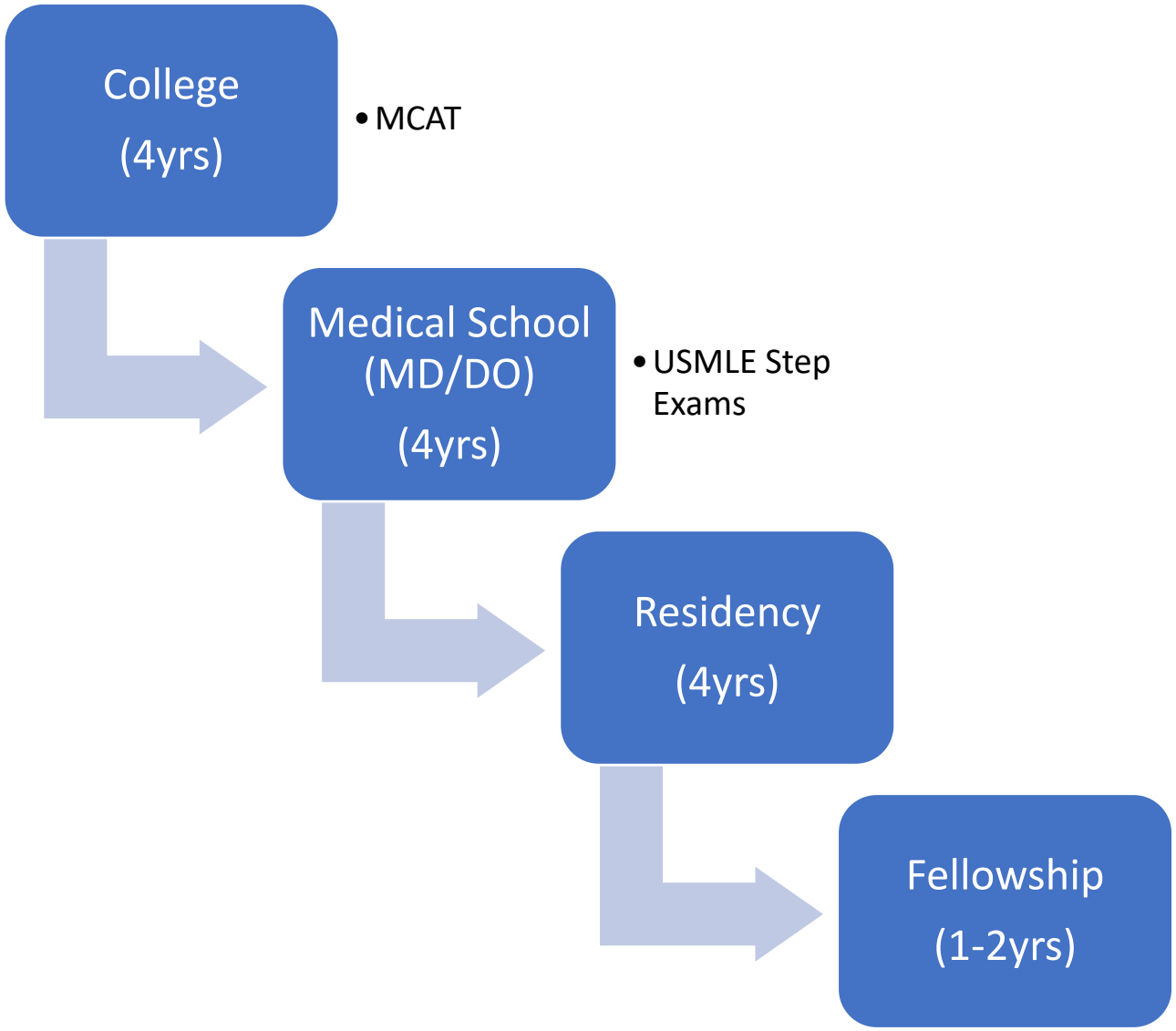
- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

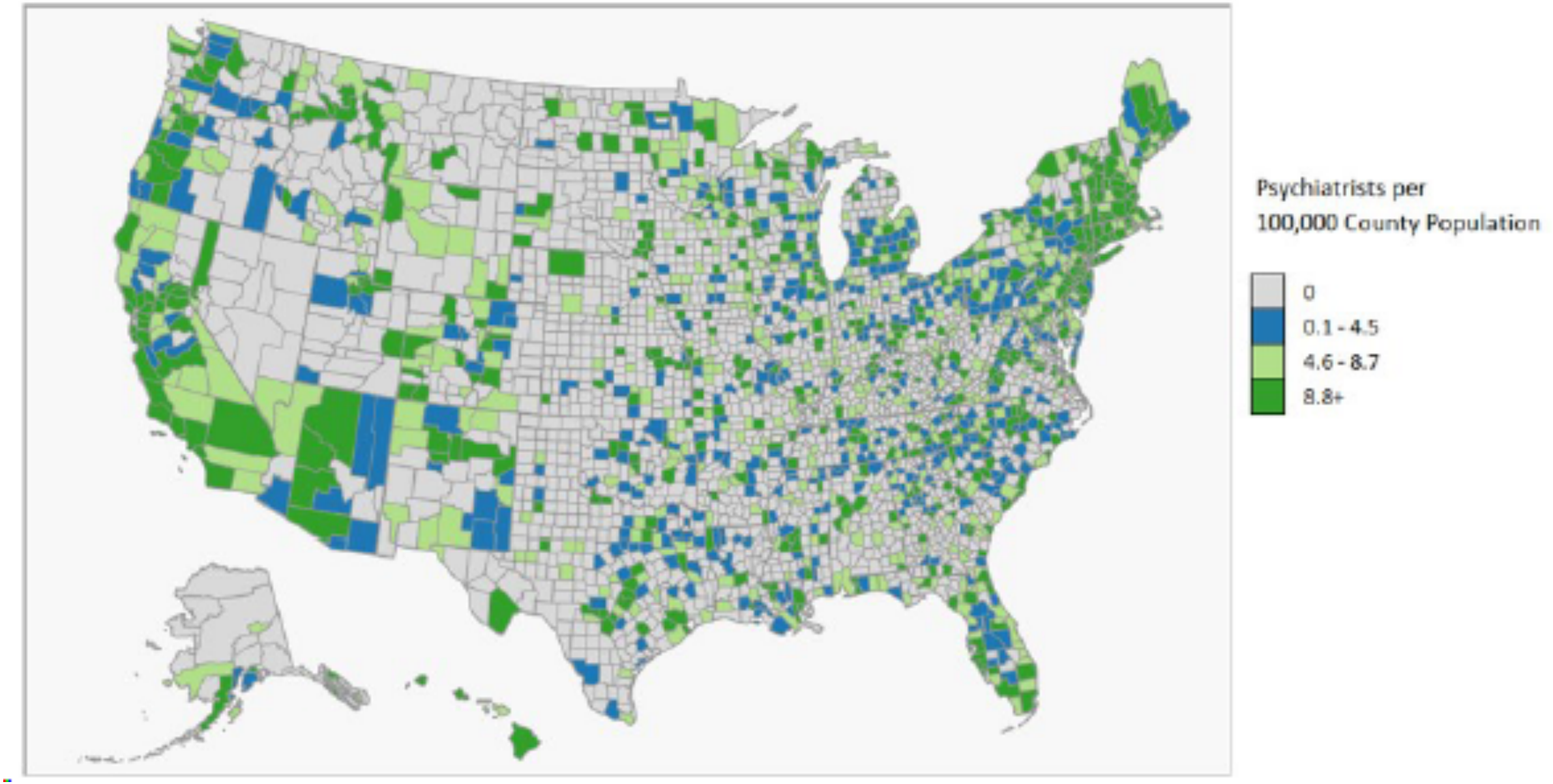
De-Mystifying Psychiatry



The Making of a Psychiatrist



- Child & Adolescent
- Geriatric
- Forensic
- Addiction Psychiatry
- Pain Medicine
- Psychosomatic Medicine
- Sleep Medicine



University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018.

Numbers

- 2nd most requested specialty needed in 2017 (9th in 2007, 13th in 2001)
- 30,451 psychiatrists active in U.S
- 9.35 psychiatrists/100,000 people nationwide
- 4,535 in CA (14.9% of psychiatrists for 12.1% of US pop)
- 41% of all psychiatrists in top 5 states
- 59% of psychiatrists > 55yo
- 1,243 psychiatrists per year will complete residencies

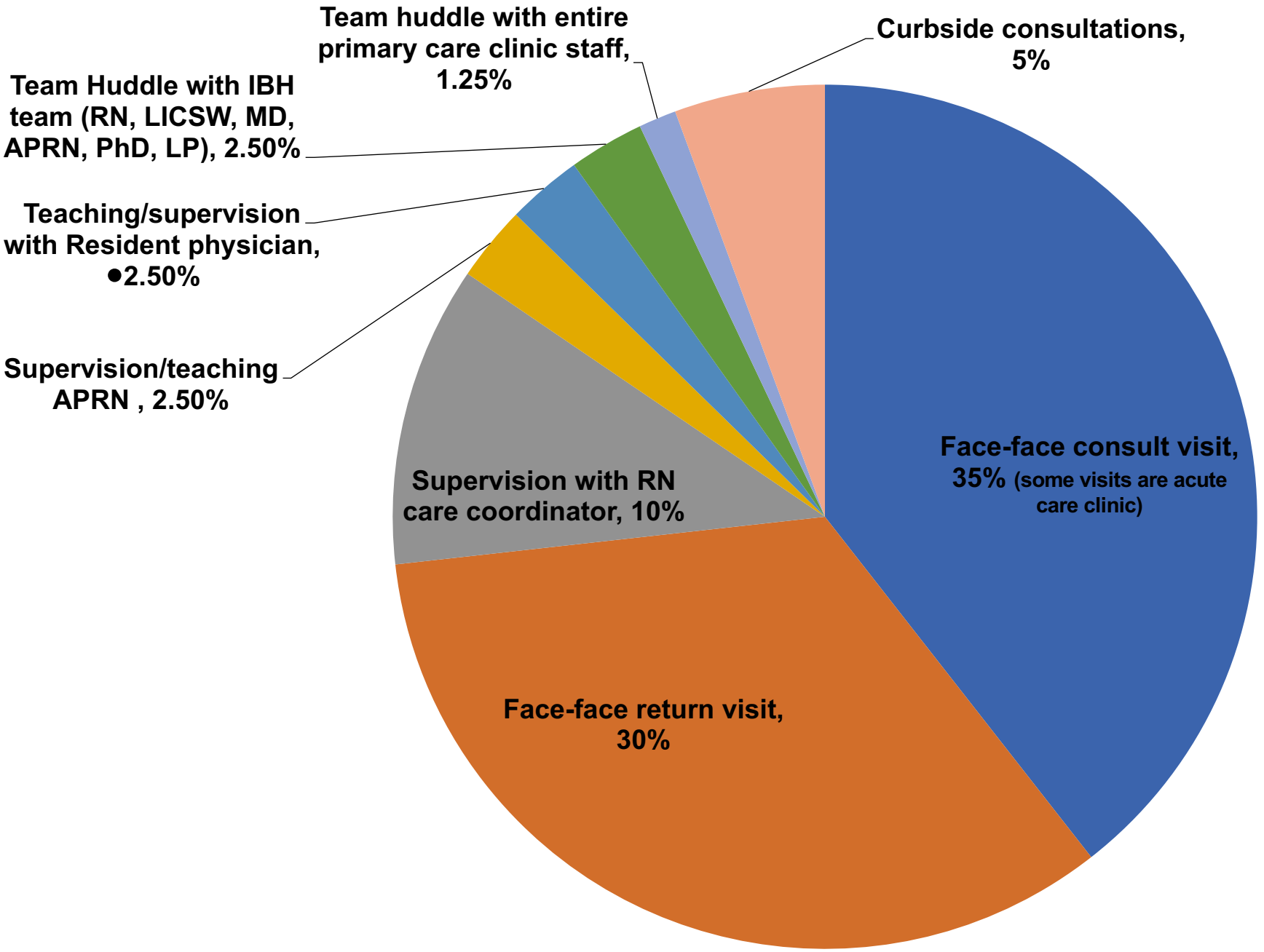
Merritt Hawkins: 2019 Review of Physician and AP Recruiting Incentives

- Wait Times
- Short Appointments
- Insurance
- Documentation Requirements

Real world perspective:
Challenges in adding Integrated Psychiatrist

- Two different worlds
  - My residency
  - My current role as psychiatrist in integrated setting

- Appreciation for Integrated/Collaborative Care as a:
  - Technology
  - Symphony
  - Start



Role of psychiatrist in integrated care setting-example of breakdown of my typical week (%time)

Challenges in adding Integrated Psychiatrist

The first face-face visit:

Explaining to the patient this is a “one time consult” or short term care

Challenges:

Patient believes they’re establishing with a long-term psychiatrist

Frustrated patient “But I saw my old psychiatrist every 3 months.”

Break from standard physician-patient relationship

Approach/Problem Solving:

1-Ensure referring provider explains IBH model

2-Explain to patient connectedness of the integrated health teams

3-Explain to patient you likely will be providing indirect care

4-Help connect patient with long term psychiatrist in select cases

Challenges in adding Integrated Psychiatrist

The complex patient with Bipolar, Schizophrenia or other SPMI

Challenges:

Patient complexity exceeds reasonable capabilities of PCP

Patient complexity exceeds capacity and model of care of integrated psychiatrist

Psychiatrist natural inclination to help patient or have unrealistic expectations of stabilizing them

Nowhere to refer patient: lack of community/long term psychiatrists

Approach/Problem Solving:

1-Start referral process EARLY: When it's clear a long term psychiatrist is needed

2-Weekly newsletter to IBH team: includes psychiatry, psychology availability and wait times in the community

3-Collaborate with community-invite community practices (Community Health Center) to your practices to streamline referral process

Challenges in adding Integrated Psychiatrist

Empowering the PCP they can take on stable:

-Bipolar, ADHD, Borderline, Schizoaffective, etc.

Challenges:

Appropriate skepticism from PCP of taking on a chronic mental illness they received very little training in managing

Approach/Problem Solving:

1-Face-Face or phone call discussion with PCP. Validate. Educate.

2-Develop and document contingencies and several next-step options

3-Utilize IBH team

(Psychology, Social Work) to identify and address gaps in treatment plan

4-Continue to teach PCP teams: presentations, decision aids, clinical tools

Challenges in adding Integrated Psychiatrist

Limitations in care coordination approaches beyond depression:

Challenges:

Developing, implementing and sustaining collaborative care models for:

-Medically complex

-Bipolar disorder

-Psychotic disorders

-PTSD

-Alcohol and drug addictions

-Patients with high utilization

Approach/Problem Solving:

1-Learning from other groups

2-Pilot and study programs:

(Mayo-Bipolar and combined medical, behavioral health care coordination)

3-Population health:

RN monitoring registry for high PHQ-9 scores, suicidal responses, behavioral health ED or hospital admissions

Challenges in adding Integrated Psychiatrist

Challenging Patient Presentations:

Treatment interfering behaviors (TIB)-many examples

Challenges:

Frustrated teams

Frustrated patient

Unrealistic expectations of behavioral health team

Patient not getting better

Approach/Problem Solving:

1-Educate (all teams members) and Define TIBs; search for underlying conflicts

2-Consult or curbside psychotherapy, therapist

3-Educate patient, set expectations, document

4-In some cases, administration, psychology involved for formal behavioral plan

Working together for the patient: **How the psychiatrist and psychologist/therapist (social worker, LICSW) work together?**

- ✓ Sort out the confusion for patients and primary care
  - ✓ Define role psychiatrist vs psychologist or therapist including scheduling errors

- ✓ Complimentary approaches
  - ✓ Alerting each other when more psychotherapy vs medication management needed

- ✓ Behavioral health team huddle meetings
  - ✓ Among other things…Humor and comradery

- ✓ Psychiatry as referral source for Group Therapy
  - ✓ CBT insomnia, depression/anxiety group, face your fears, pain group)

- ✓ Referral to Acute Care Clinic for patients on brink of hospitalization/ED
- ✓ Behavioral plans for challenging patients
- ✓ Mayo Rochester: Psychologist and Psychiatrist as division co-chairs

Case: “I took a few extra pills”

- 55-year-old woman with schizoaffective, multiple medical problems, chronic struggles
- Managed in primary care with intermittent visits with integrated psychologist, psychiatrist (both know patient well).
- Discussed at “huddle” frequently-social work helps with referral to more community services like case management
- Patient decompensates: several psychiatric hospitalizations and multiple ED visits over 6 months.
- “I took a few extra pills” patient tells psychologist via patient portal online message.

- **Next steps?**

Case 2: Trajectory

- 21-year-old woman with MDD and anxiety.
- Struggles, had to drop out of college.
- IBH psychiatry consult: suspect Bipolar II, added bipolar medications. Enrolled in Bipolar Care Coordination
- Difficult next 2-3 years
  -Unemployed, high symptom burden, 1 suicide attempt and 1 hospitalization
  -Borderline traits, referred to DBT:
  -But… **Invaluable insights and management from RN care coordinator** (insights: conflicts with mother, trauma history, alcohol use, patient education, collateral with outside psychotherapy)
- Current:
  -Stabilizes on medications, psychotherapy, sobriety, improved self-management
  -Employed as teacher, saving for return to college, improved relationship with parents
  -PCP messages about galactorrhea-suspects it is secondary to quetiapine, asks for dose reduction.
  -Provided psychopharmacology education and recommended MRI--pituitary mass diagnosed, surgery planned

Access remains a problem

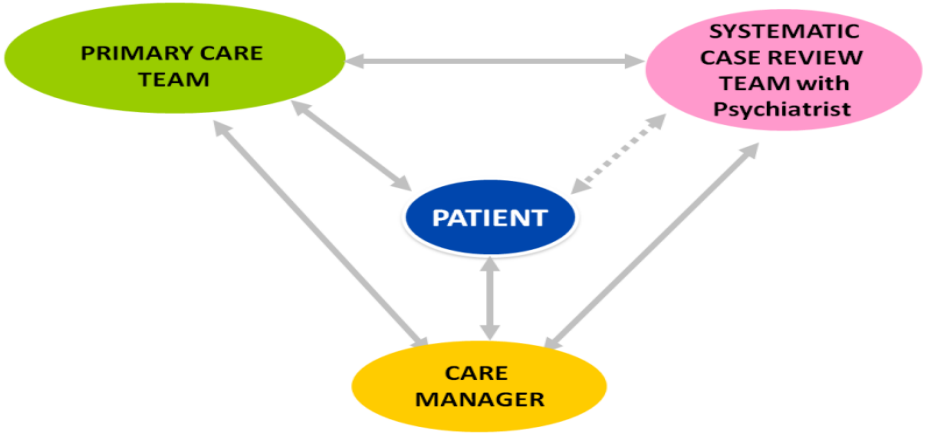
- Would need 4 times the current mental health resources to address the need
  - Way more work than all of us in mental health could possibly manage
    - Suggests need for new models to address a population
- In primary care, look to redefine access
  - Not just face-to-face visits
  - Access to support or information to get the patient started down the right path sooner.
  - Make the case for ways to improve capacity as value added requiring support from administration versus fee-for-service

Force multiplication and raising capacity

- Goal = increase capacity
  - From impacting one patient to many
- Teaching primary care providers
  - Opiate calculator, Ask Mayo Expert
  - Shared decision tool for choice of antidepressants
  - Curbside consults – ‘doc of the day’
- Care Coordination
  - Telepsychiatric options and case-based learning
- ECHO project (University of New Mexico)
  - Case-based teaching

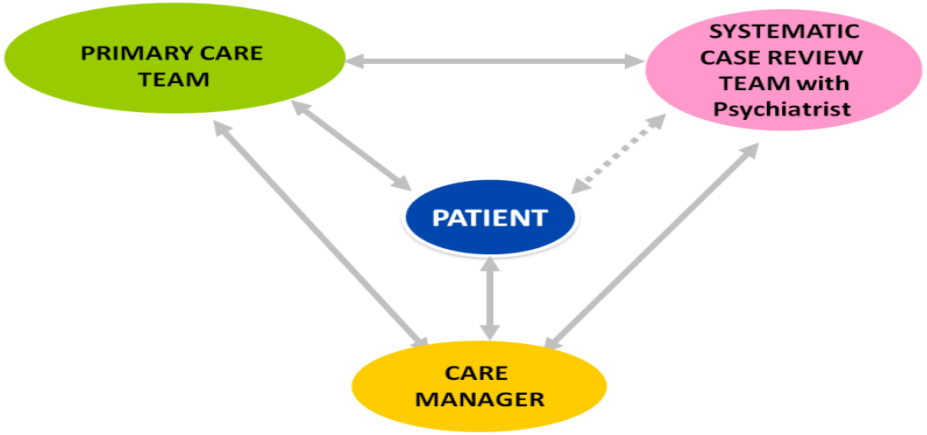
  Lesson: Can this information be taught?

What model of care coordination – IMPACT model



- Patient see by Primary Care/show up on eligibility list
  - PHQ-9 score ≥ 10 (moderate)
- Patient introduced to RN care coordinator/contacted
- Patient agrees to participation?
  - More data gathered from patient
    - GAD7, MDQ, AUDIT
    - Past history, social situation, meds, etc.
- Data entered into a **registry** and presented to Psychiatrist (meet once/week) in systematic case review (SCR)

Then what happens?



- Psychiatrist makes recommendations into the patient chart for the primary care provider
  - Typically three areas of recommendations
    - (1) Medical (meds or address medical issues) (2) therapy (suggested need) (3) behavioral activation
- Primary care provider writes all prescriptions
- Psychiatrist and nurse care manager stay involved and track outcomes until the patient reaches remission
  - or as good as it is likely to get and connected to needed care (1 year max).
- Patient is discharged back to their primary care team or to higher level of care

Care coordination from psychiatrist perspective

- Review and provide feedback on 40-50 patients in two hours
- Tracking outcomes versus providing a consult and then following up in 2-3 months
  - Allows for more informed triage
- In weekly input to the primary care provider and review of cases with care coordinator
  - Case-based learning – provide suggestions and justification
  - Keeps psychiatrist on his/her toes as primary providers get more sophisticated

Paying for the Psychiatric Provider

- Direct Evaluations – 90792, 99204 99205, 99213, 4, 5
- Indirect Evaluations – “curbside” or other consultation only
  - Collaborative care codes – 99492 - 494
  - Medicare Interprofessional codes
  - Code 99451 is reported by the consultant, allowing him/her to access data/information through the electronic health record (EHR), in addition to telephone or internet.
  - Code 99452 is reported by the requesting/treating physician/QHP (e.g., the primary care physician).
  - Find value and incorporate into budget (like ECHO hub, etc) esp if in VBP arrangement

CPT Codes for CoCM

99492 – first 70 minutes - $161

99493 – subsequent months - $129

99494 – each additional 30 minutes - $67

99484 - $48/20 minutes once a month

G0512 -$134 (FQHCs only)

Billed once a month under PCP's NPI

- Outreach and engagement by BHP
- Initial assessment of the patient, including administration of validated rating scales
- Entering patient data in a registry and tracking patient follow-up and progress
- Participation in weekly caseload review with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

The "Right Stuff"
Effective Implementation: 9 Factors

Table 1. Factors Considered Important for Implementation of DIAMOND

Ranking	Implementation Factor	Definition
1	Operating costs of DIAMOND not seen as a barrier	The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.
2	Engaged psychiatrist	The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.
3	Primary care provider (PCP) "buy-in"	Most clinicians in the clinic support the program and refer patients to it.
4	Strong care manager	The care manager is seen as the right person for this job and works well in the clinic setting.
5	Warm handoff	Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.
6	Strong top leadership support	Clinic and medical group leaders are committed and support the care model.
7	Strong PCP champion	There is a PCP in the clinic who actively promotes and supports the project.
8	Care manager role well defined and implemented	The care manager job description is well defined, with appropriate time, support, and a dedicated space.
9	Care manager on-site and accessible	The care manager is present and visible in the clinic and is available for referrals and patient care problems.

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

Whitebird, Jaeckels Kamp et al. Am J Manag Care. 2014;20(9):699-707

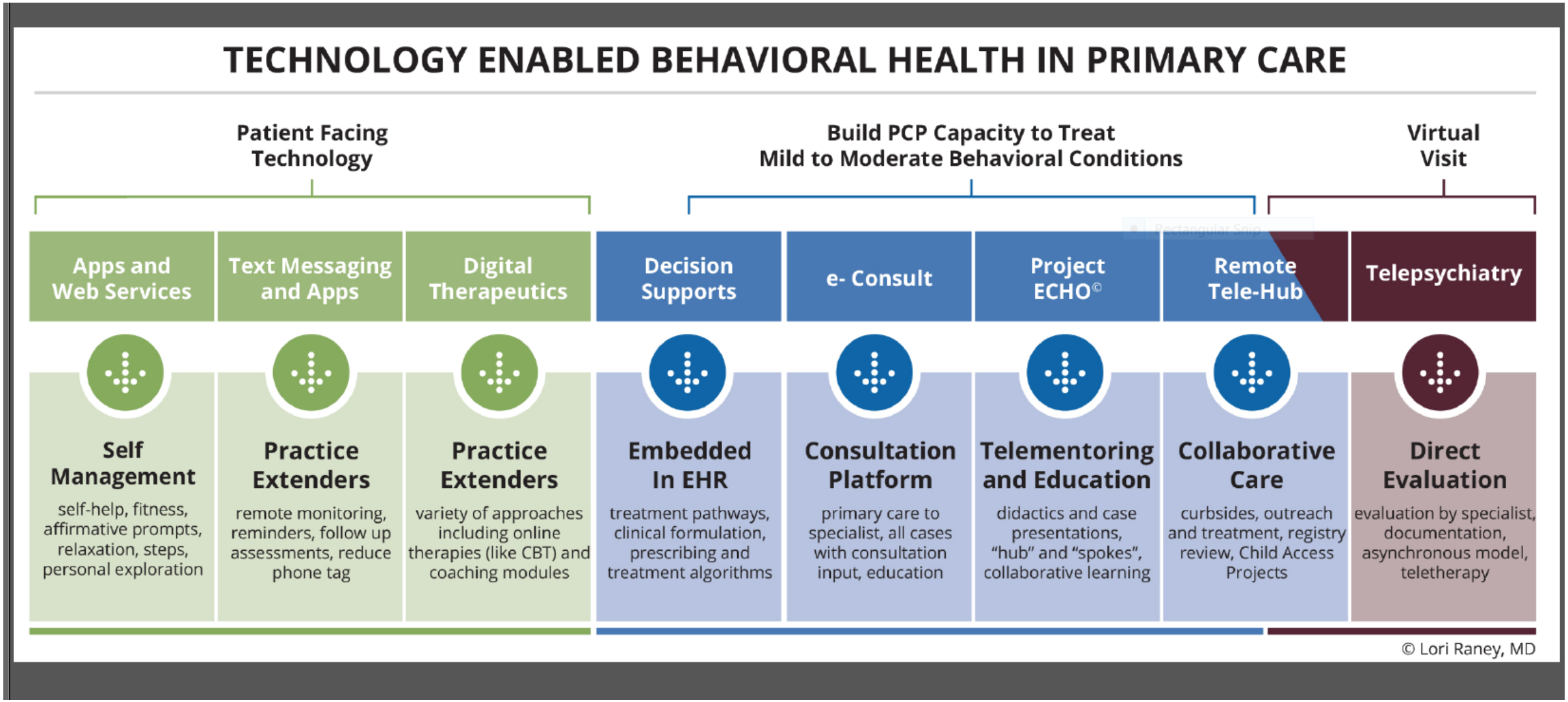
“Engaged” Psychiatric Provider

- Do you/care managers *meet routinely with the psychiatrist* for the weekly 2 hour meetings?
- Is the psychiatrist *friendly and helpful* with your/cm review of patients in your caseload?
- Does he/she give *feedback, direction, suggestions* for both pharma and other therapeutic approaches to getting the patient to goal
- Do the *psychiatrist and PCP’s ever connect*?
- If the PCP contacts the consulting psych in between the weekly sessions, does he/she typically *get back to the PCP in a timely manner?*
- Has the psychiatrist done any other types of *in-services or education sessions* for your PCPs, your care managers, and/or care teams?
- Do you have any concerns about the consulting psychiatrist working on your team?

Psychiatric Provider Best Suited for this Work

- Flexible – expect the unexpected
- Adaptable - child and other populations
- Willing to tolerate interruptions
- Able to manage liability concerns and do curbsides
- Like teaching
- Enjoy being part of a team
- Willing to lead
- **Training resources are available

Blessed are the flexible for they shall not get bent out of shape.



Raney L, et al: Current Psychiatry, October 2017

Other Ways to Leverage Psychiatric Expertise

- Improving Outcomes and Costs With System-Level, Physician-Led Interdisciplinary Case Review

  Leonard J. Rosen, M.D., Amanda Nixon, L.M.S.W., Laurin Jozlin, L.M.S.W., Pamela Keesling, B.H.S.A.

  Interagency, Interdisciplinary Team Work, Clinical Leadership by a Psychiatrist led Team with High Cost Patients over 3 years

  - 35% reduction in inpatient days
  - $825,000 saved

- Tele-teaming
- Store and Forward Consultation
- Behavioral Health Bunker
- Project ECHO
- eConsult
- One and Done

Psychiatric Services 2019; 70:436–439; doi: 10.1176/appi.ps.201800176

Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Join us next year in Philadelphia, Pennsylvania! Thank you!