Integrated Care Training Program

UW Psychiatry & Behavioral Sciences

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Working effectively with PCPs and their diverse skill set through the lens of case consultation

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Speaker Disclosures

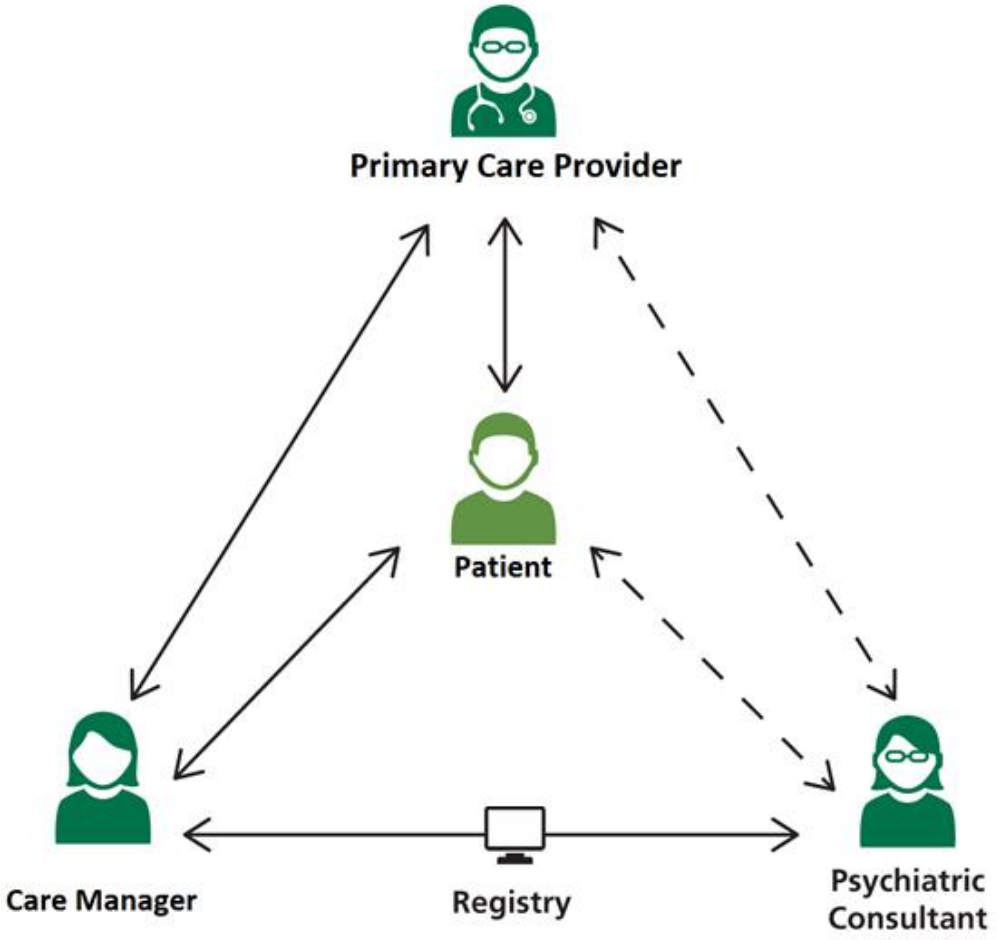
- Nothing to disclose

Learning Objectives

1. How to recognize varied **clinical competencies** and support PCP manage mental health conditions effectively.
2. How to judge PCPs interest and adapt to varying **levels of engagement**
3. How to respond to PCPs **varied expectations** of your role in CoCM

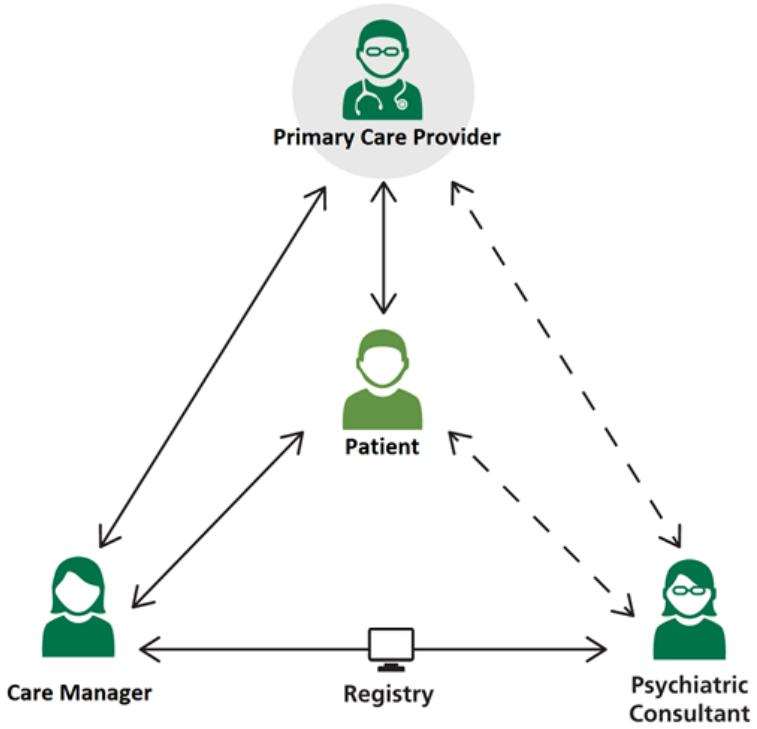
(Collaborative Care Model=CoCM)

Collaborative care team



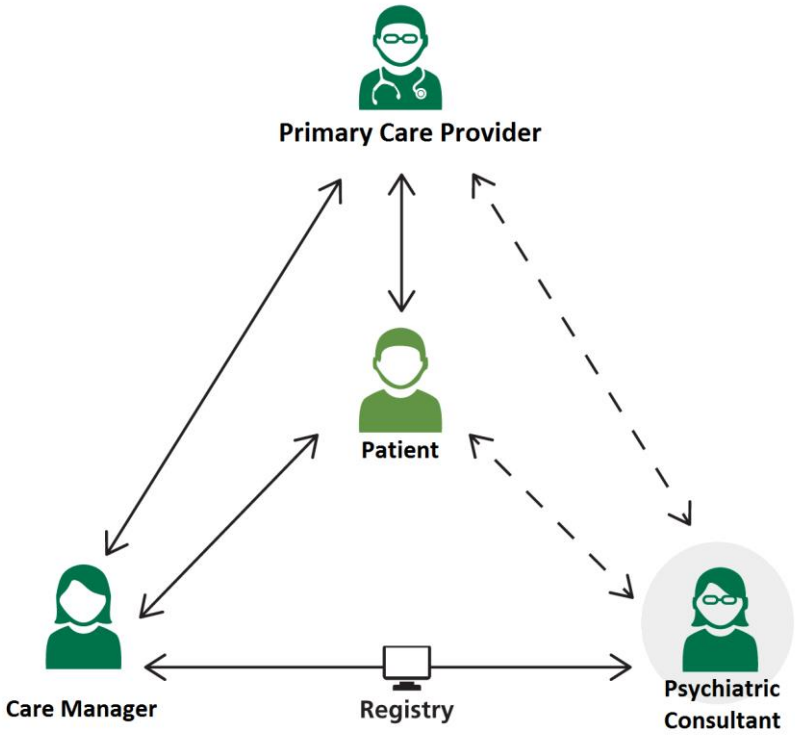
Primary Care Provider (PCP) Role

- Primary treatment relationship
- Links with collaborative care team
- Prescribes medication
- Monitors medication management, together with care manager
- Supports treatment plan
- **Consults with collaborative care team**
- **Supports system change**



Psychiatric Consultant (PC) Functions

- Review cases with the CM using the registry
  - Scheduled (weekly)
  - Prioritize patients not improving
- Consult urgently (as needed) with PCP or CM



Principles of Collaborative Care

Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

Why is this important?

- PCPs can make or break your CoCM program
  - Referral source
    - All or nothing phenomenon
  - Explains the program and consents the patient
  - Sets expectations
  - Receives/implements recommendations
  - Exerts positive peer pressure

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

Why is this important?

- PCPs come to CoCM from various backgrounds
  - Personal experience
  - Training experience
  - Clinical experience

- PCPs bring different expectations to CoCM
  - “Take Over”
  - Teammate

Why is this important

The consulting psychiatrist can impact PCP engagement.

- "The Engaged Psychiatrist"
  - Highest correlation to depression remission rates at 6 months in large state-wide implementation of CoCM
- Helps build expertise of team
  - Provides timely feedback
  - Educational sessions
  - Friendly

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

The Take-over referral

Mr. B is a 65-year-old patient with no prior past psychiatric history and longstanding mild back pain. He is referred from his PCP to the CoCM team for new-onset anxiety and panic attacks (heart palpitations, flushing, SOB, lightheadedness) in the last two months in the setting of increased work stressors. On reviewing the referral, you note no prior psychotropic medication trials.

PE: unremarkable

Labwork, including CMP, CBC, and TSH, are WNL.

65yo M with anxiety and no treatment trials

- What do you wish to see in a referral like this?
- What are opportunities for improvement in the care of this person at the time of the referral?
- How can you communicate back suggestions for improvement to your PCP teammate?

65yo M with anxiety and no treatment trials

- What are some areas of clinical competency that may need to be addressed that emerge from this referral?

- Is this PCP engaged, to what extent, and how could this be improved?

65yo M with anxiety and no treatment trials

- The PCP perspective

- The Consulting Psychiatrist perspective

The Strong-Partner referral

Ms. A is a 35-year-old patient with a past history of Bipolar disorder who was referred for depression. She is now 4 weeks into treatment within CoCM. Her PHQ9 remains unchanged at 17, with #9-1, and she is feeling more irritable and her sleep has been disrupted. Prior to referral her PCP initially started Sertraline, but then switched after 2 days to Duloxetine 30mg qday. 2 weeks after that switch she was started on Bupropion for augmentation. 1 week later, Trazodone was prescribed for sleep. CoCM recommendations to start a mood stabilizer has not been followed.

35yo F with depression and emerging hypomania.

- What do you wish to see in a referral like this?
- What are opportunities for improvement in the care of this person at the time of the referral?
- How can you communicate back suggestions for improvement to your PCP teammate?

35yo F with depression and emerging hypomania

- What are some areas of clinical competency that may need to be addressed that emerge from this referral?

- How would you engage a PCP who may not be listening to your recommendations?

35yo F with depression and emerging hypomania

- The PCP perspective

- The Consulting Psychiatrist perspective

Make all PCPs CoCM Champions!

- How well do you know your PCP teammates and their mental health skill set?
  - Clues from the caseload review
    - Missed diagnoses
    - No medication trials
    - Non-evidenced based practices
    - Limited referrals
    - Others?

Take aways

- Look at your referrals carefully to provide insights into your PCP skillset
  - Any trends to address?
  - Is a targeted intervention needed?

- Look to stay “Engaged” with you PCP teammates
  - Remote work makes it harder

Craven, MA, et al. Can J Psychiatry. 2006;51(6 Suppl 1):7S-72S

Take aways

- Is the SYSTEM a problem?
  - extensive physician education that spanned a 12-month period
    - Included case-by-case consultations, didactics, academic detailing (eg, clearly stating the educational and behavioral objectives to individual physicians), and role-play of optimal treatment.

Result: No change in use of meds, depression outcomes, etc

Lin, EH, et al. Med Care. 1997;35(8):831-842

THANKS

Resources

- AIMS Center office hours
- UW PACC
- Psychiatry Consultation Line
  - (877) 927-7924
- Partnership Access Line (PAL)
  - (866) 599-7257
- PAL for Moms
  - (877) 725-4666

Questions and Discussion

- Ask questions in the chat or unmute yourself

Registration

- If you have not yet registered, please email uwictp@uw.edu and we will send you a link