# Psychiatric Consulting in Primary Care: An Introduction to Practice in an Integrated Care Team

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| **Module 1:** Introduction to Primary Care Consultation Psychiatry  
This module describes basic structure of an integrated care program for behavioral health in a primary care setting. The development of integrated care in response to the needs and challenges related to behavioral health care in primary care is reviewed. The evidence base for collaborative care is described. The roles for a primary care consulting psychiatrist are defined. | |
| **Module 2:** Building an Integrated Care Team  
This module describes the process of developing and implementing an integrated care team. The primary care environment, the core principles of collaborative care, the roles of the collaborative care team members and the tasks/components of a collaborative care team are reviewed. | |
| **Module 3:** Psychiatric Consulting in Primary Care  
This module discusses the common primary care psychiatric presentations observed in primary care. Common approaches to providing treatment in a primary care setting, working with the other providers in a collaborative care team and practice considerations for consulting in a collaborative care program are also reviewed. | |
| **Module 4:** Behavioral Interventions and Referrals in Primary Care  
This module provides a brief overview of common health behavior change recommendations and the basic principles of brief psychotherapeutic interventions appropriate for delivery in a primary care clinic. The process for triaging patients to appropriate referrals and evaluation for disability are also presented. | |
| **Module 5:** Medical Patients with Psychiatric Illness  
This module describes the principles of chronic illness care and how they apply to behavioral health. Approaches to identify and treat common medical co-morbidities, to integrate chronic pain and pain management strategies into treatment plans and to provide primary care behavioral health to special populations are reviewed. | |
## Module 1: Introduction to Primary Care Consultation Psychiatry

**Learning Objective(s):** By the end of this module, the participant will be able to:

1. Make the case for integrated behavioral health services in primary care.
2. Discuss principles of and approaches to integrated behavioral health care.
3. List the evidence for collaborative care.
4. Describe roles for a primary care consulting psychiatrist in an integrated care team.

### Content

#### Overview of primary care psychiatry

- **i.** Current landscape: Unmet needs in primary care; Psychiatrist shortage
- **ii.** Advantages of primary care based mental health
- **iii.** CMS driving healthcare system transformation

#### Models of mental healthcare: Spectrum of care

- **i.** Traditional
- **ii.** Liaison/Co-location
- **iii.** Collaborative Care

#### Essential components of a collaborative care program

- **i.** Patient Centered Care: Team-based care: effective collaboration between PCPs and Behavioral Health Providers.
- **ii.** Population-Based Care: Behavioral health patients tracked in a registry: no one ‘falls through the cracks’.
- **iii.** Measurement-Based Treatment to Target
- **iv.** Evidence-Based Care
- **v.** Pay for Performance

#### Evidence base for collaborative care

- **i.** Meta-analysis of collaborative care models
- **ii.** Research Example: IMPACT
- **iii.** Endorsements
- **vi.** Real World Example: MHIP

#### Primary care consulting psychiatrist

- **i.** Multiple roles: Clinical leader, caseload consultant, direct consultant, clinical educator
- **ii.** A day in the life of a primary care consulting psychiatrist
- **iii.** Is primary care consulting psychiatry for you?

### ACTION

#### Reflective Thinking

1) Is primary care psychiatry for me?
   - a. Clinical leadership role at interface of mental health and the rest of health care?
   - b. Enjoy sharing, communication, and teaching?
   - c. Can live with uncertainty common in primary care?

2) 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)

1) 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.
RESOURCES (Websites, Articles, Tools, etc…)

For consulting psychiatrists:
- AIMS Center: http://uwaims.org

Resources to provide to your team:
- Information for PCPs from Washington State Integrated Care Program: http://integratedcare-nw.org
- CIHS
  Patient Centered Primary Care Collaborative: http://www.pcpcc.net/

References:


### Module 2  Building a Collaborative Care Team

**Learning Objective(s):** By the end of this module, the participant will be able to:

1. Explain the leadership role of a psychiatric consultant in a collaborative care team.
2. Describe the primary care practice environment in which an integrated team functions.
3. Define the members and roles of an integrated behavioral health team.
4. Develop an efficient and effective work flow for their integrated care team. Identify training and other needs to support an effective team.
5. Apply knowledge to help implement an integrated care team

### Content

**Program Development**

1. Leadership role of the consulting psychiatrist
   - Administrative
   - Clinical
2. Leading the development of an integrated care program

**Primary Care Perspectives**

1. High medical co-morbidity
2. Fast paced; “short” visits; Focused on acute needs
3. Working in a team is part of modern health care

**The Integrated Care Team Building Process**

1. Define Tasks
2. Assess current resources and workflow
3. Define team member responsibilities integrated workflow
4. Assess hiring and training needs

**Core Components and Tasks**

1. Identifying patients/Need for screening tools
2. Engaging patients in integrated care
3. Use of evidence based treatment
4. Systematic follow-up/Tracking systems
5. Communication and care coordination
6. Systematic case review by consulting psychiatrist
7. Program oversight and quality improvement

### ACTION

**Reflective Thinking**

1) What is the environment of the primary care practice where I consult?
2) What are my strengths as a clinical leader?
3) What will be challenging for me in a leadership role?
4) Who are the primary care champions for me in this effort?

**Adapt to Practice (including team building)**

1) Define the workflow tasks for your collaborative care program
2) Identify the champion in the primary care practice you serve
3) Coordinate with all behavioral health providers
4) Complete the teambuilding process
5) Help implement an effective collaborative care workflow
RESOURCES (Websites, Articles, etc…)


# Module 3  Psychiatric Consulting in Primary Care

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<th>Learning Objective(s): By the end of this module, the participant will be able to:</th>
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## Content

### Clinical epidemiology of the primary care clinic

1. Wide variety of presentations/ Need to triage
2. Clinical presentations common in primary care:
   - Unexplained physical symptoms/ Somatic presentations/Somatoform disorders

### Working with behavioral health providers/care managers

1. Who are they? Training and skill sets of different types of providers; What makes a good BHP/Care Manager?
2. Care manager role/ Therapists role: Identifying strengths and building trust
3. Providing caseload supervision (managing the caseload); Providing clinical supervision; Providing education around clinical decision making

### Working with primary care providers

1. Selling the program/process to the PCP and addressing resistance to integrated care
2. Availability
3. Medication Recommendations: Evidence-based treatments and treatment algorithms in primary care
4. Psychiatric crises/ Working with difficult patients

### Assessment and diagnosis in the primary care clinic

1. Functioning as a “back seat driver”
2. Use of screeners for case finding and tracking symptoms – mental health “vital signs”
3. Balancing complete vs sufficient information for a diagnosis
4. Developing a provisional diagnosis

### Caseload Consultation and Making Treatment Recommendations

1. Common consultation questions
2. When patients do not improve: Clarification of diagnosis, Address treatment resistant disorders etc.
3. A different kind of note
4. Consultation tools: Tracking system

## ACTION

### Reflective Thinking

1. How will my practice adapt to a primary care setting? What will be challenging for me about adapting my practice to a primary care setting?
2. What are my strengths in working in a team? What will be challenging for me about working in a team?
3. Are there specific topics related to primary care psychiatry that I need to learn more about?

### Adapt to Practice (including team building)

1. Define the structure of your consultation to BHPs/Care Managers
2. Map the work flow for communicating information from consultations to your PCPs
3. Identify any areas and resources for information to enhance your knowledge
4. Tailor treatment protocols to your practice setting

## RESOURCES (Websites, Articles, etc.)


## Module 4: Behavioral Interventions and Referrals in Primary Care

### Learning Objective(s): By the end of this module, the participant will be able to:

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<tbody>
<tr>
<td>1</td>
<td>Integrate health behavior change recommendations into treatment plans for primary care settings.</td>
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<tr>
<td>2</td>
<td>List the basic principles of common brief psychotherapeutic interventions including motivational interviewing, distress tolerance, behavioral activation and problem solving therapy.</td>
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<tr>
<td>3</td>
<td>Triage patients to appropriate referrals for common primary care behavioral health presentations.</td>
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<tr>
<td>4</td>
<td>Support primary care providers in functional assessments including assessing disability for primary care patients.</td>
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### Content

#### Brief Psychotherapeutic Interventions

i. Health Behavior Change and Motivational Interviewing

ii. Distress Tolerance Skills

iii. Problem Solving Therapy

iv. Behavioral Activation

#### Referrals

i. Serious persistent mental illness in primary care settings

ii. Substance use treatment

iii. Social Service needs: Housing, Food, Basic needs

#### Disability

i. Assessing disability

ii. Vocational rehabilitation

### ACTION

#### Reflective Thinking

1) How do I integrate behavioral recommendations into my treatment planning?

2) How do I feel about assessing for disability as part of a treating team?

#### Adapt to Practice (including team building)

1) Determine the skill level of team members to provide various behavioral interventions

2) Develop a referral resource list

3) Identify pathways for vocational rehabilitation in your community

### RESOURCES (Websites, Articles, etc...)

#### Motivational Interviewing:


#### Distress Tolerance:


#### Behavioral Activation:


Problem Solving Therapy:


Disability:


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### Module 5 Medical Patients with Psychiatric Illness

**Learning Objective(s):** By the end of this module, the participant will be able to:

1. Describe the principles of chronic illness care and how they apply to behavioral health.
2. Identify common medical co-morbidities and provide treatment recommendations that take these into consideration.
3. Integrate chronic pain and pain management strategies into treatment plans for behavioral health.
4. Discuss behavioral health approaches to special populations.

#### Content

**Principles of Chronic Illness Care**

1. Population-based
2. Practical, supportive, evidence-based interactions
3. Informed, activated patient
4. Prepared, proactive practice team

**Chronic pain and pain management**

1. Relationship between physical and emotional pain
2. Pharmacological interventions
3. Non-pharmacological interventions

**Medical Comorbidty**

1. Coordinating care with PCP
2. Common disorders: Diabetes/Metabolic syndrome
3. Common Disorders: Cardiovascular disease
4. Common Disorders: Other

**Special populations**

1. Geriatric
2. Children/Adolescent
3. Pregnant women
### ACTION

#### Reflective Thinking

1. What role do I see for myself in addressing medical co-morbidity in my consultations?  
2. How comfortable am I in addressing chronic pain as part of my practice?  
3. Do I have enough experience to provide consultation to the special populations in my practice?  

#### Adapt to Practice (including team building)

1. Name the ways in which your current practice is proactive in the identification and treatment of medical co-morbidity  
2. Name the ways in which your current practice is proactive in the identification and treatment of chronic pain  
3. Identify the special populations you serve and adaptations of your practice needed to meet special needs

### RESOURCES (Websites, Articles, etc…)

#### Chronic Pain:


#### Medical Co-morbidity:


#### Pregnancy and Lactation:


#### Older Adults:
