Collaborative Care Management:

Psychiatry on Demand

You may have heard a lot about Behavioral Health Integration, and you may have welcomed into your practice a psychologist or social worker, either to co-locate or to help patients manage their behaviors that help or hinder their wellness: diet, exercise, weight management, medication compliance, smoking, etc. Collaborative Care Management is an additional, complementary subset of Behavioral Health Integration that incorporates a consulting psychiatrist and a care manager (or psychiatric assistant – like a medical assistant trained in psychiatry) into the practice to provide timely, effective mental health care.

Traditional "treatment as usual" of mental health disorders has not done well for patients or primary care providers, for mostly structural reasons. A lack of psychiatrists, particularly in rural areas, means many PCP's have no choice but to provide even very complex care, yet primary care schedules do not allow for long enough appointments to do a thorough enough history to come to a solid diagnosis, and the rhythm of primary care is set up for acute illness. It's easy for the patient to neither improve nor return for a new approach.

In the Collaborative Care model, when the patient comes into the clinic with a mental health concern, the PCP can give the patient over to the psychiatric assistant (PA) in a warm handoff, so the patient doesn't have to wait for care. The PA gathers the extensive history needed to make a good diagnosis and sends it to the consulting psychiatrist who makes the diagnosis and suggests treatment plans, so there is always an expert involved. The PCP remains in control of the treatment, and the patient and the PCP decide on the treatment plan. The PA contacts the patient regularly and, using standardized outcome scales specific to the diagnosis, monitors the patient for improvement. This way, the PCP always knows how the patient is doing and whether the plan is working. Patients are not lost to follow up and they have better treatment outcomes: side effects are caught quickly, treatment is changed until it works, and the patients feel cared about and become more engaged in their care. The PCP never has to sacrifice their lunch or dinner hour to take the needed time to gather diagnostic information. The PA is on-site and available to help triage suicidal patients, buffer the provider from unneeded calls, and help get the patient community resources. The PA effectively extends the psychiatrist by about 5-fold. A single psychiatrist can therefore cover several clinics over a wide geographical area and still be readily available for curbside consults and questions. If a primary care office has an existing behaviorist or social worker, the PA can support those too: the services are complimentary, and the PA can free up time for the clinical practitioners to focus on treatment.

There is about 40 years of evidence demonstrating the effectiveness of collaborative care and the reality that collaborative care saves money for the health system. It's better AND cheaper! Consequently, SAMHSA and CMS have a big push to get primary care practices to adopt collaborative care, and so having it helps with both Medicare "stars" and clinical metrics. The American Psychiatric Association has free training for each member of the team (https://education.psychiatry.org/Users/ProductDetails.aspx?ActivityID=4834) or independent companies can help you set up your own service or even provide a complete service to overlay onto your existing practice with minimal disruption.

Caroline Fisher MD PhD
Germane & Wise Mental Health Systems Consulting, LLC
cfisher@germanewise.com