Telepsychiatry Consultation Care Model in Rural Primary Care

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Learning Objectives

- At the end of the presentation, participants should be able to define and discuss the consultation care model.
- Participants should be able to identify and discuss the clinical guidelines of providing telepsychiatric care as defined by the American Telemedicine Association.
- Participants should be able to identify and discuss common psychiatric disorders and treatments that present in rural primary care.
- Participants should be able to perform a Suicide Risk Assessment on patients who present with suicidal ideation.
The Burden of Mental Illness

Adults

- For Any Mental Illness
  - In 2014, nearly 1 in 5, or roughly 43 million adults had a diagnosable mental disorder
  - 18.1% of all U.S. adults

- For Serious Mental Illness (SMI)
  - In 2014, there were 9.8 million adults
  - 4.2% of all U.S. adults

Children

- In 2014, 20% (1 in 5) children ages 13-18 currently have or have had a serious mental disorder

- Disorders regularly seen in primary care include
  - ADHD
  - Conduct Disorder
  - GAD
  - Depressive Disorders
  - PTSD
  - Separation Anxiety [1]

World Health Organization

- The World Health Organization has identified the “urgent importance” of integrating mental health into primary care to address the global burden of mental health conditions [1]

- Integrating the two is the most viable way to close the treatment gap and ensure patients get the mental health care they need [1]
Mental Health and Primary Care

- Mental and physical health problems are interwoven
  - Anxious and depressed mood initiate adverse changes in endocrine and immune functioning and can make people more susceptible to physical illness
  - Mental disorders can compromise health behavior [1]
Mental Health and Primary Care

- Decrease the treatment gap for mental illness
- Enhances access
- Minimizes sigma and discrimination
- Affordable and cost effective
- Generates good health outcomes [1]
Mental Health and Primary Care

- First level of care
- Early identification of mental disorders
- Management of stable psychiatric patients
- Referral to other levels of care when required
- Attention to the mental health needs of people with physical health problems
- Mental health promotion and prevention [1]
Mental Health and Primary Care

- Primary care medicine is crucial to mental health care delivery in rural areas [2]
- Primary care providers in rural areas report having inadequate skills to manage mental-health issues and feel they would benefit from assistance [3]
- In the US, a majority of patients with mental health concerns receive treatment from their primary care physician
- Access to specialists is a problem [2]
Mental Health and Primary Care

- If clinics have to refer patients elsewhere for treatment, less than one third of the referrals are completed [4]

- Lack of mental health services leads to
  - under-treatment
  - poor outcomes
  - increased use of emergency services
  - increased number of hospitalizations
  - Increased placement in mental health institutions [2]
Mental Health and Primary Care

- Primary care is a major access point for depression treatment.

- Primary care physicians are facing the burden of an increasing number of patients with major mental illness [4].

- Primary care physicians are taking on more prescribing authority for patients with complex mental health issues [4].
Depression in Primary Care

- 12.5% of primary care patients have MDD [5]

- Primary care manages about 1/3 to 1/2 of non-elderly adults and nearly 2/3 of older adults who receive treatment for MDD [5]

- Of those with MDD
  - 47% are recognized clinically
  - 24% receive any treatment
  - 9% receive adequate treatment
  - 6% achieve remission [5]
Primary Care Depression Treatment

- Identification of depression has improved
- Comorbid alcohol problems frequently remain unidentified/untreated
- Treatment is often too short or otherwise inadequate
  - 2007 study found 46% of depressed patients received 2 or more months of treatment. (4-9 months after remission of symptoms is recommended) [10]
  - Most patients unresponsive to initial treatment did not have their medication adjusted
Inadequate Trials of Antidepressants in Primary Care

• Of those receiving any health treatment, only a subset are likely receiving *adequate* treatment

• Based on NCS-R (National Comorbidity Survey Replication)
  • 64% of those being treated in the mental health sector
  • 41% of those being treated in the general medical sector

• Adequate depression treatment
  • At least 4 medication monitoring visits in the prior year
  • Regular evaluation of depressive symptom response and side effects
  • Increasing antidepressant dose if response has not been achieved
  • Reasonable dose and duration for the treatment = at least a moderate dose for at least 6-8 weeks [5]

• Patients receiving tele-health services are more likely to receive adequate doses of antidepressants and recover from depression [3]
Barriers to Off-Site Treatment

- Negative beliefs associated with mental health care
- Lack of transportation/cost of transportation
- Distance from provider
- Limited clinic hours
- Inability to get an appointment
- Insurance coverage [4]
- Even with significant funds available for travel, patients might prefer to see someone in a familiar place [3]
Access

- Increased access to consulting psychiatrists is needed to provide optimal management of an increasing number of patients with mental illness within primary care [4]
Telepsychiatry

- Telemedicine technology is one way to improve the accessibility of mental health care to areas underserved by psychiatrists [3]
- Telepsychiatry has been used to link specialists at academic health centers with primary care physicians in rural areas [3]
- Telemedicine was first used for medical purposes for psychiatric consultation in the 1950s to help the Nebraska Psychiatric Institute provide care and consultation to various sites [3]
Telepsychiatry

- In the 1960s, telemedicine was also used to connect academic centers with urban populations [3]
- University health systems are now increasingly reaching out with telemedicine to rural clinics
- A Consultation-Care model is often used because it is practical and able to reach a broader number of sites [3]
Consultation-Care Model

- Includes the primary care physician as the principal provider of mental health services
- The consulting psychiatrist provides
  - an opinion about diagnosis or differential diagnosis
  - recommendations about further diagnostic testing that may be helpful
  - management options
    - including providing several medications options when medications are deemed appropriate
- The PCP, with the specialist’s help, provides most of the physician-based clinical care, in combination with nurses, educators, and therapists
  - The PCP always maintains prescriptive authority
- Role of the psychiatrist is as a consultant and educator [6]
- The recommendations given by the consulting psychiatrist may or may not be implemented by the primary care provider
- University and academic health systems often use this model of care because it is practical and reach a broader number of patients
Consultation-Care Model

- The consultant psychiatrist does not order medications or additional tests.
- The consultant psychiatrist does not build a caseload of patients to follow on a routine basis.
- The consultant psychiatrist covers a broad range of age groups and diagnoses and is prepared to provide recommendations in a variety of areas [6].
- The psychiatrist has access to electronic records and can see patient’s current medications, medical conditions, labs, vitals, and behavioral health notes [6].
Education

- An important aspect of the consultation-care model
- Occurs with the intent to build the capacity of the primary care doctor to treat mental health conditions
- Every consultation is an opportunity to teach
- Helps primary care providers and behavioral health providers gain confidence in their skills
- The consulting psychiatrist is also a learner in this process [6]
Patient Population and Diagnoses

**Patient Population**

**Telepsychiatry Outcomes:**
- Patient Population
  - Adult: 61%
  - Child: 39%

**Initial Diagnoses**

**Telepsychiatry Outcomes:**
- Patient Diagnoses
  - Mood Disorders: 67%
  - Psychotic Disorders: 8%
  - Adjustment Disorders: 8%
  - Developmental Disorders: 17%
Final Diagnoses

- Major Depressive Disorder
- Unspecified Depressive Disorder
- Substance Induced Depressive Disorder
- Disruptive Mood Dysregulation Disorder
- Bipolar Disorder
- General Anxiety Disorder
- Social Anxiety
- Post-traumatic Stress Disorder
- Specific Phobia
- Obsessive Compulsive Disorder
- Attention Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Neurocognitive Disorder
- Schizoaffective Disorder
- Intellectual Disability
- Adjustment Disorder
- Alcohol Use Disorder
- Opioid Use Disorder
- Conversion Disorder
- Cannabis Use Disorder
- Social Communication Disorder
## Benefits of Telepsychiatry Consultation

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<thead>
<tr>
<th>Benefits</th>
<th>Limitations</th>
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<tr>
<td>Access to care and services</td>
<td>Limited access</td>
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<td>Savings of time, costs, and</td>
<td>Limited follow-up</td>
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<td>travel</td>
<td>Require full intakes</td>
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<td>Improved patient convenience</td>
<td>Limited communication</td>
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<td>Decreased time waiting for</td>
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Clinical Guidelines for Telepsychiatry

- Provider and patient identity verification
- Provider and patient location documentation
- Contact information verification for professional and patient
- Verification of expectations regarding contact between sessions
- Obtaining informed consent with the patient in real time
- Communication and collaboration with the patient’s treatment team
- Emergency management
- Documentation and record keeping [7]
Suicide Risk Assessment

- Patients dying by suicide visit primary care physicians more than twice as often as mental health clinicians [9]
- Generalists (internists, pediatricians, and family physicians) write 62% of antidepressant prescriptions in the US [9]
- Those with current psychiatric illness are the most common group dying by suicide [9]
- Mood disorders (bipolar disorder and depression), substance use, anxiety, impulse control disorders, personality disorders, and psychotic disorders are associated with suicide
- Most common psychiatric illnesses seen in primary care are anxiety, depression, and alcohol use disorders [9]
Don’t Ask, Don’t Tell, Don’t Know

- Suicidal thoughts and behaviors are poorly managed
  - 2007 study found suicidal ideation was only assessed in 24% of patients [10]
- When identified, generalist physicians typically neither treated it themselves nor referred patients for mental health consultation [10]
Suicide Assessment

- **Who?**
  - Every patient being evaluated for possible depression
  - Every patient with a history of depression
  - Every patient with a history of psychiatric disorders
  - Every patient with a history of suicidal thoughts or attempts

- **How?**
  - Start with a general question and get more specific with each successive question
Suicide Assessment

- 4 main questions
  - Hopelessness or thoughts of death
  - Explicit thoughts of suicide
  - Specific plan and means to carry it out
  - Intention to carry it out [10]

- Patient’s family history of suicide
- Patient’s previous suicide attempts
Suicide Assessment

- Yield may be low, but stakes are high
- In a 2009 study, nearly 1000 patients were screened for depression and suicide in a cardiology clinic
  - 109 (12%) expressed suicidal ideation
  - 4 patients required emergent hospitalization [11]
References


