

**Robert Lee Sutherland Seminar XV  
Hogg Foundation for Mental Health**

**Concurrent Session I: Integrated Care Team Roles  
Summary Notes**

**Goals of the session included:**

- Understanding the role of integrated team members
- Developing a sense of supports that help team members transition to new roles

**Panelists focus on:**

- Delivery of care provider roles
- Next steps to take at local and state levels
- What does and does not work
- Role of the mental health provider, physical health provider, and psychiatrist

**Panelists:**

- Dr. Robin May-Davis: Psychiatrist who works with the EMerge Program
- Rachel Quintanilla: Social Worker and counselor, focuses on crime victims, clinical manager with El Paso's Project Vida
- Joann Gilbert: Consumer who receives integrated health services
- Dr. Richard Peavey: Specializes in occupational and rehabilitation medicine, director of adult medicine at People's Community Clinic in Austin

**Dr. Robin May-Davis:**

- Austin Travis County MHMR partners with Austin community health centers on the EMerge Program, covers 13 clinics
- 6 years of integration via the EMerge Program
  - She was added as a second full-time psychiatrist in the EMerge Program
- Consultations begin with the primary care physician and referrals are made to behavioral health counselors (bilingual, full-time staff members)
- Screening is conducted to determine if a psychiatric referral is warranted (referrals are typically made for more severe conditions such as dementia or schizophrenia)
- Consultations vary and may be curbside (i.e., providing quick recommendations), involve topical questions (i.e., What is used to treat X?), or formal consultation
- There is an overflow of those who don't get into traditional MHMR centers
- A small number of patients will have follow-ups, and usually include those who have more complicated conditions (cases in which the primary care physician will need more assistance)
- Transitions back to the primary care physician have been smooth overall (due to strong buy-in to the integrated model)
- Patient will be started on treatment and medications and/or labs may be ordered, but outside referrals are not made by psychiatrist
- The psychiatrist makes notes for the primary care physician to consider (electronic medical records enable notes to be sent quickly)

- Patients are informed that they need to follow-up with their primary care physicians in the next few months
- There is less continuity of care than what exists in traditional mental health treatment
- Advantages of this integrated model are opportunities to provide first time management, psychoeducation, teaching moments with the primary care physician
- Psychiatrists serve as a liaison for specialty mental health and don't conduct traditional psychotherapy

### **Rachel Quintanilla:**

- Rachel works as a care manager for the Project Vida Health Center in El Paso, Texas
- She operates by a team mentality, in which the patient is at the center (as the most important person) and is surrounded by the primary care provider, care manager, consulting psychiatrist, and cognitive-behavioral therapist
- Patient encounters involve administration of the PHQ-9 and OASIS screeners (given every time patient is seen)
  - The care manager assistant scores the PHQ-9 and OASIS for the provider and passes the information to the care manager
  - The care manager logs the information into the Web Registry (the registry is a database that is programmed to prompt follow-ups and track treatment adherence and response)
- Front desk clerk will attach the screener to the chart for the physical health provider to enable the provider to know if there is a concern (to know whether the patient has significant depression or anxiety)
- The provider then reviews the PHQ-9 and OASIS, and mental health problems may be suspected if scores are very low or if a patient's affect isn't congruent with scores (i.e., sad affect with high scores)
- The physical health provider may discuss the patient with the care manager at this point (i.e., discussing possible causes for screening scores such as illiteracy, or personal circumstances)
- The provider will then offer an initial diagnosis and determine the appropriateness of psychotropic medication(s) (the care manager will provide psychoeducation regarding the medication(s) for the patient)
- At this point, the patient is referred to the case manager
- When the care manager interviews patients, they usually visit in her office
  - The care manager can quickly catch patients before they leave the clinic because her office is situated by the nurse's desk
  - Where the care manager is situated in the clinic is important
- The care manager decides if the patient will receive cognitive-behavioral therapy (CBT) (a referral to the therapist is made) and the patient can be introduced to the therapist if he/she is on site
- The patient can be referred to a partnering counseling center or MHMR
- The care manager can also inform the physical health provider that a patient may have a difficult time starting therapy, and may benefit from a low medication dose (previously as a therapy provider medications were not a concern)

- Care management involves use of assessment tools, psychoeducation, treatment adherence, therapy (at times), and phone or in-person follow-ups
- Care management does not equal case management
  - The care manager does not transport patients
  - The care manager does not make appointments
  - The care manager does not conduct Social Work tasks
- The care manager does the following:
  - Gives references to other collaboration agencies
  - Consults with providers for treatment implementation
  - Provides the patient with psychoeducation on depression and anxiety
  - Reviews the Web Registry for “outliers”-reported scores not improving, missed appointments, adherence to medication and counseling, etc.
  - Makes phone or in-person follow-ups
  - Coordinates contacts among providers including the consulting psychiatrist
  - Sometimes provides CBT
- The care manager engages in a weekly 2-hour psychiatric consultation with the psychiatrist (this is a case review to discuss who is doing well, medications, and for the psychiatrist to supervise the work done with patients)
- The psychiatrist’s treatment recommendations are conveyed to the primary care physician
- After meeting with the psychiatrist, the care manager will open the patient’s chart and enter a “blank note” which involves adding the psychiatric information to the electronic system and routing the information to the provider (the note also indicates if the information is urgent or is a normal case review)
- Psychiatrist’s role involves:
  - Weekly psychiatric consultation
  - Working directly with primary care provider or patients (clarifying behavioral health treatment options / diagnostic issues and addressing myths and fears)
  - Capacity building impact (medication updates, diagnosis and treatment elements)
  - Consulting on specific cases (clarifying diagnoses, medical regimen)
- Relapse prevention
  - Care management continues until patient improves and stabilizes
  - Continued monthly follow-ups
  - Before termination, the care manager helps the patient plan for and prevent future psychiatric episodes
- Cognitive-behavioral therapy
  - Evidence-based
  - Brief version
  - Cultural adaptations (modify CBT to reflect the Latino culture)
  - On-site and off-site
- First year results
  - 150 under care
  - Approximately 40% have attained 50% improved after >10 weeks (off-site counselor administration and on-site counselor changes)
  - Staff buy-in (importance of administration, primary care physician, and support staff buy-in to model)
  - Partnering agencies’ cooperation is key also

- Clinical barriers
  - Clinical barriers involving the primary care physician include: limited training in psychiatric disorders and their treatment, hesitance to consider psychiatric disorders within their scope of practice, and stigmatizing attitudes toward mental illness
  - Clinical barriers involving patients include: variable treatment adherence and stigmatizing attitudes toward mental illness
- Lessons learned:
  - Collaboration is most important in an integrated model (this enables the focus to be the patient)
  - Work as a team
  - Primary care physician and support staff champions are critical
  - Psychiatrist and care manager need to establish trust with primary care physicians
  - Once implemented, primary care physicians quickly see the benefits and late adopters come on board
  - Care manager's personality may be more important than credentials
  - Collaborative care approach reduces stigma as a barrier to treatment seeking
  - Co-morbid conditions (especially substance abuse and chronic pain) must be addressed
  - Creative partnerships facilitate model

**Joann Gilbert:**

- As a consumer, Joann liked Project Vida because the services a patient needs to receive are all in the same location
- It took time to adjust to the screeners given at each appointment
- When she first received her diabetes diagnosis, she didn't think the physicians cared, but is now very satisfied and happy with the services provided at Project Vida

**Dr. Richard Peavey:**

- The aspect of being part of a team is valuable
- A team approach enables you to count on others in the team to understand the patient and make recommendations that a physical health provider may not be able to
- The whole patient is treated in a collegial setting (by consulting with others such as the social worker and psychiatrist)
- Prior to being a member of an integrated care team, Dr. Peavey would not know if a patient would return for future services
  - The physical health provider is typically not able to follow-up with the patient, but a counselor is able to and in this model the physical health provider is confident that the patient will return
- This is a new model – previously, the provider would try to send a patient to the psychiatrist but may not have enough information to make an appropriate referral
- It makes a difference to be able to track outcomes
- In every treatment setting, you decide who to treat based on available resources
- Use of electronic patient tracking forms is beneficial (indicates date, scores on PHQ-9 and OASIS screening measures, medications, visit type, charts patients progress, etc.)

### **Lessons learned:**

- Even if you have buy-in at the top, it can be difficult to get the providers to break away from the parallel play model, keep working with providers and keep them trained and updated, many of them are not comfortable with mental health
- Obtaining outcomes can be very satisfying, those who haven't tried to collect outcomes should try it
- Give screening instruments to patients
- The primary care physician and support staff are critical in the integrated model, the psychiatrist and care manager need to develop trust with the primary care provider
- The care manager's personality is just as important as credentials, if not more important
- A collaborative care approach decreases the stigma to treatment seeking
- Co-morbid conditions must be addressed
- Creative partnerships facilitate the model

### **Questions and Answers**

- Please describe the screening measures and what they are used for.
  - PHQ-9 is a nine question screener that identifies depression, ratings on scale of 1-4 (patients rate themselves over past two weeks, and one question assesses for safety by asking about suicidality)
  - OASIS is an anxiety screener that indicates the level of anxiety a patient has experienced during the past two weeks
- What prepared them for their new roles?
  - Dr. Peavey – a psychiatrist prompted him to work in collaboration, with good counseling resources you may not need a psychiatrist, the primary care physician's role is still to write the prescription
  - Rachel Q. – she had experience giving psychosocial assessments, she honed her knowledge of the DSM (psychiatric diagnostic manual) and diagnostic skills, cognitive-behavioral training, Hogg trainings, researching pertinent information on the American Medical Association and American Psychiatric Association websites
  - Dr. May-Davis – becoming oriented with primary care settings, becoming more familiar with pain management issues, using email or electronic records in order to efficiently communicate patient information to other team members
  - Rachel Q. – learning to read prescriptions
  - Joann G. – it was helpful to have diagnoses and therapy approaches such as cognitive-behavioral therapy explained by team members
  - Team members should educate patients regarding how this new system, the consultative model (vs. the traditional mental health model) works
- What roles do hope and spirituality play in the model?
  - Work to find out what spirituality was like before X happened
  - Exploration of spirituality needs to be comfortable for the patient first
  - Integrated care is more holistic, so a broader approach is emphasized
  - Hope is central to the whole process of healing

- Can telemedicine work for remote communities in need of services?
  - Rather than using telemedicine immediately, try using midlevel professionals such as social workers
  - Telephone consultation is available for remote areas
  
- Differences between care manager and social worker?
  - A social worker assists in location of social service resources
  - A care manager will provide follow-up counseling and make sure that a patient adheres to treatment