Integrating Mental Health and Primary Care

Brief, Focused Provider Consultation

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Primary care providers are taking on more responsibility for mental health care than ever before. This model uses psychiatric consultation on specific patient issues to support primary care providers and improve the quality of referrals.

In DoD, VA, and civilian health care settings, the responsibility for managing mental health problems increasingly falls to primary care providers. With the military's heightened emphasis on preparing for deployments and maintaining a fit and ready force, DoD mental health staff often are occupied with active duty concerns, leaving primary care providers to pick up the slack in the areas of dependent and retiree mental health care. Many VHA facilities offer mental health care in a specialty clinic setting, to which patients are referred only after primary care interventions have proved unsuccessful. Furthermore, VA patients referred to a psychiatrist often must wait up to six months for a follow-up appointment, which adds to the pressure on VA primary care providers to treat individuals they might otherwise have referred to mental health specialists. Finally, in the civilian sector, especially underserved, rural communities, access to psychiatric consultation may be less than timely.[1]

Although some primary care providers are highly competent at dealing with psychiatric issues, several studies suggest that these providers often miss mental health diagnoses—particularly depression.[2] In addition, primary care providers may be more likely than mental health care providers to prescribe suboptimal regimens that overemphasize the biological aspects of the condition.[3] In the air force, the problem is compounded by the fact that *Air Force Instruction 48-123—Medical Examinations and Standards* (*AFI 48-123*),[4] the document that guides providers in assessing service members' mental and physical fitness for duty, uses outdated psychiatric terminology and principles and, therefore, is of minimal practical use to primary care providers.[5]

For all these reasons, mental health consultation within primary care can be beneficial in terms of

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diagnosis, assessment, and treatment.[6] Numerous publications have addressed the interactions between mental health and primary care, but many of these base their analyses solely on physicians' perceptions. In this article, I present retrospective data on a model of psychiatric consultation in primary care that I developed and implemented at Tinker Air Force Base, OK in order to improve triage and preliminary biopsychosocial treatment planning by primary care providers. Unlike most previous studies, this one gathered data from consultation forms, as well as a subjective provider survey. The goals were to define more clearly the types of mental health concerns for which primary care providers seek expert psychiatric advice and to evaluate the effect of this model on providers' ability to manage mental health care effectively. Overall, the intent was to enhance understanding of the process of consultation with a psychiatrist.

DEVELOPING A CONSULTATION MODEL

There is much debate over the optimal model for mental health consultation in primary care (M.J. Higgins, unpublished data, September 15, 2002). Many primary care practices have adopted behavioral health models that use nonphysician mental health care providers,[6] but these models may offer insufficient aid with such medicine-oriented issues as medication management, substance abuse (including outpatient management of withdrawal), and psychiatric comorbidities of medical diagnoses (such as systemic lupus erythematosus, multiple sclerosis, and hepatitis C). Often, nonphysician mental health specialists have minimal experience with these issues. And while the behavioral interventions these providers may recommend for such patients are important, there still may be subtle diagnostic and treatment issues involving nonpsychiatric conditions and medications that nonphysician providers may be unable to address to the extent required by primary care providers.

If, however, psychiatrists are to collaborate with primary care providers, what specific role should they play and how can their time be used most effectively and efficiently? In the past, primary care providers typically received didactic psychiatric instruction a few times a year and referred patients with complicated management issues to psychiatric care.

But several studies, including one that reviewed 50 years of medical literature,[7] have concluded that ongoing interactions between psychiatrists and primary care providers—occurring within the family medicine setting and focusing on specific patient issues—are superior to this model in terms of both provider education and patient care (M.J. Higgins, unpublished data, September 15, 2002).[7,8] Problems with traditional psychiatric referrals include, from the patient and primary care provider's perspective, long delays between referral and the first psychiatric appointment (typically a minimum of four to six weeks in both the public and private sectors), and from the psychiatrist's perspective, unnecessary referral of patients whose cases could be managed satisfactorily in the primary care setting.

Both primary care and psychiatric providers recognize that, for some patients, input from a psychiatrist on certain specific diagnostic or therapeutic issues could have a significant impact on the patient's outcome, but it may not be necessary for the psychiatrist to meet with the patient. Often, focused, five- to 10-minute "sideline" consultations can improve management of the patient's psychiatric condition substantially. In fact, many psychiatrists field quick, simple questions from primary care colleagues regarding psychiatric dilemmas. In theory, a model that expands on such brief interactions could improve primary care providers' ability to manage psychiatric conditions and ensure more appropriate psychiatric referrals while helping to contain health care costs (a critical administrative concern).[9]

These concepts formed the foundation of the consultation model—called brief, focused provider consultation (BFPC)—established at Tinker Air Force Base. As the name implies, the model involves brief communications between the primary care provider and the psychiatrist that allow the psychiatrist to make recommendations regarding a specific patient's treatment without having to interview the patient directly. The ultimate goal of the program was to promote enhanced, timely patient care while maintaining the responsibility of treatment within the primary care setting as often as possible. An additional objective was to expand primary care providers' knowledge base and comfort levels regarding psychiatric issues.

Under the BFPC model, the psychiatrist performs "walk rounds" around the primary care offices two to three times a week during the providers' administrative hours. The primary care providers set aside patient charts, notes, or

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questions regarding specific patients to discuss at this time.

During each consultation, the primary care provider presents a brief patient history, with the psychiatrist asking follow-up questions to clarify or expand upon any ambiguous areas. The primary care provider then raises relevant issues for discussion. At the close of the session, a consultation form documenting the interaction is placed in the medical chart with a copy maintained in a mental health consultation file.

ASSESSING BFPC

As the staff psychiatrist at Tinker Air Force Base, I implemented BFPC in 1999 and continued using it until my departure in 2002. During this time, the primary care clinic was operating with 14 providers: six family physicians (all MDs), one internist (a DO), six physician assistants, and one nurse practitioner.

After one year of using BFPC, I performed a retrospective review of the consultations provided that year, with a specific focus on the types of issues discussed and the patterns of recommended referrals. I collected relevant data from the consultation forms. In addition, I administered an anonymous survey assessing primary care providers' satisfaction with and perceptions of the model.

STUDY RESULTS

During the one-year period between January 1 and December 31, 2000, there were 188 psychiatric consultations with primary care providers involving 131 patients. A total of 57 consultations, therefore, involved patients previously discussed or seen in follow-up by the primary care provider. Despite the issue of base transfers in the military setting, the number of primary care nurse practitioners, physicians, and physician assistants remained the same during this review period.

Types of consultations

Although many consultations began with the primary care provider posing a specific question, multiple issues frequently were discussed. More than half (55%) of the consultations involved discussion of diagnostic issues (Table 1). Pharmacologic therapy and medical complications also came up frequently in the consultations.

Referral patterns

Of the 131 patients for whom the psychiatrist was consulted, 50 warranted psychiatric referral and were interviewed by the base psychiatrist. Among these 50 referrals, 40 had their psychiatric care transferred to mental health, while 10 were one-time consultations with primary care retaining responsibility for continued management. An additional 24 patients were referred through the TRICARE network to nonmilitary psychiatrists (Table 2). During the study period, therefore, the BFPC model allowed primary care providers to continue managing mental health care for 67 (51%) of 131 patients whose conditions necessitated consultation with the psychiatrist—with 57 patients (44%) not needing to meet with a psychiatrist at all.

Other types of TRICARE referrals recommended during BFPC discussions included neurology, psychotherapy, pain clinic, substance abuse treatment, and sex therapy. In total, TRICARE refer-

Table 1. Topics discussed in brief, focused provider consultations performed at Tinker Air Force Base between January 1 and December 31, 2000

Topic	No. (%) of consultations* (n = 188)
Diagnostic issues	103 (55%)
Pharmacologic treatment	91 (48%)
Medical complications	77 (41%)
Psychosocial treatment	49 (26%)
Workup/laboratory studies	47 (25%)
Pain management	38 (20%)
Complex disease management	24 (13%)
Medication adverse effects	23 (12%)
Military protocol	17 (9%)
Substance abuse	10 (5%)

*Many consultations involved discussion of multiple issues.

rals were recommended for 37 patients, some for multiple types of treatment.

Provider satisfaction

In January 2001, I hand-delivered the provider satisfaction survey to the 14 individuals filling the clinic's primary care provider slots at that time, with a 100% response rate. The survey asked providers to rate the BFPC model's effectiveness in several areas of patient care, using a five-point scale in which 1 represented "least effective" and 5 represented "most effective."

Respondents' ratings were high overall, with all areas receiving mean scores above 4 (Table 3). When all primary care providers were considered together, mean scores were highest in the areas of group referrals and diagnosis, followed closely by overall mental health care and medication management. Considered separately, physicians (MDs and DOs) gave group referrals the highest score possible (5). Among nonphysician providers (nurse practitioners and physician assistants), group referrals and medication management both received a high score of 4.71.

The survey included space for providers to comment about the program. Eight providers made use of this space, indicating that the psychiatrist was "available" and "helpful with referrals." There were no negative comments.

IMPLICATIONS OF THE FINDINGS

Overall, the results of this retrospective review suggest that primary care providers are interested in receiving input on a broad spectrum of psychiatric issues, from differential diagnosis and evaluation to medical comorbidities and biopsychosocial treatment (including specific medication management questions).

It's not surprising that diagnostic issues came up so frequently in the consultations. With many primary care models using appointment slots of 15 minutes or fewer, primary care providers often have insufficient time to differentiate fully between diagnoses with similar symptoms, such as adjustment disorder with depressed mood, dysthymia, depression, and depressive symptoms secondary to a medication or general medical condition. This differentiation often is critical to effective treatment. For example, while an antidepressant may be beneficial for a wide range of patients with depressive symptoms, this is not the case for patients with different anxiety disorders: A medication effective for generalized anxiety disorder

Table 2. TRICARE referrals recommended as a result of brief, focused provider consultation

Type of referral	No. (%) of patients* (n = 37)
Psychiatry	24 (65%)
Psychotherapy	14 (38%)
Pain clinic	10 (27%)
Substance abuse treatment/detoxification	7 (19%)
Sex therapy	2 (5%)
Neurology	2 (5%)
Other	7 (19%)

*For some patients, multiple TRICARE referrals were recommended.

Table 3. Results of provider satisfaction survey regarding the effectiveness of brief, focused provider consultation in improving specific patient care areas

Patient care area	Mean satisfaction rating*		
	MD/DO	PA/NP	Overall
Overall mental health care	4.57	4.43	4.50
Medication management	4.29	4.71	4.50
Mental health, substance abuse, or medical issues	4.30	4.29	4.31
Diagnosis	4.57	4.57	4.57
Group referrals	5.00	4.71	4.86

*Rating scale was from 1 to 5, with 1 representing "least effective" and 5 representing "most effective."

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may not help a patient with panic disorder.

Unfortunately, many behavioral health models used in primary care overemphasize symptoms at the expense of accurate diagnosis. Furthermore, concomitant Axis II maladaptive personality traits and symptoms relating to a patient's past experiences, such as bereavement or posttraumatic stress disorder, often go undiagnosed. These nuances can have great clinical relevance, but eliciting them takes time and patient trust. Consultation can offer the provider clinical pearls or follow-up questions that, in turn, may lead to a more accurate diagnosis and more appropriate treatment.

The subtlety of such treatment issues as medication management, potential adverse effects of psychotropic agents, appropriate follow-up care, and treatment of partially remitted mental health conditions also can be handled through consultation. Some primary care providers may be uncomfortable going beyond the starting dose of a psychotropic drug or may not follow up on a depressed patient for several months. The importance of access to expertise regarding medication management issues for primary care providers has been underemphasized and even minimized in the past. This may be due, in part, to the use of nonpsychiatric mental heath providers who have minimal experience regarding medication issues. In the present study, almost two thirds of the consultations discussed medication issues in some form (including both pharmacologic treatment choices and adverse effects of medication).

Issues with nonpsychiatric dimensions—namely, the connections between mental disorders and physical conditions (such as migraines, thyroid disease, and fibromyalgia), pain issues, psychiatric adverse effects of nonpsychotropic medications, or workup concerns—were discussed in 162 consultations. In particular, the use of medications for psychiatric and medical comorbidities seemed to be a topic on which primary care providers frequently sought help. In settings without a neurologist or pain management specialist, the psychiatrist may well be the resident expert on these topics.

Over one third of the consultations in this study included discussions of nonpharmacologic psychosocial group therapy and supportive interventions (included in the psychosocial treatment and complex disease management categories). In a busy primary care practice, medications frequently are considered as the only treatment option, or access to other interventions may be perceived as unattainable in a short period of time. Often a simple reminder about individual, marital, family, or group therapy—or another community-based supportive intervention—can lead to appropriate referrals and, thus, improved patient care. In settings in which there are no other behavioral health specialists, a psychiatrist consultant can take on the important role of suggesting such nonpharmacologic interventions.

Of note, only 17 consultations in this study addressed military-specific or readiness issues. This number was lower than expected, based on both the fervor and ambiguity associated with determination of status issues involving deployability, flying, profiling, Medical Evaluation Board (MEB) concerns, fitness for duty, and the Personnel Reliability Program. These areas are tremendously important from an operational standpoint, especially when dealing with troops in crisis.

The fewer than expected number of military-related consultations may reflect recognized problems within *AFI 48-123*.[5] For example, while this document clearly recommends the initiation of MEB proceedings for a patient with schizophrenia, the provider must use his or her own clinical discretion regarding such diagnoses as generalized anxiety disorder and major depression. Furthermore, *AFI 48-123* uses terminology that is not consistent with modern diagnostic codes. And though an outdated term such as "psychoneurotic" may be merely frustrating to a psychiatrist, it can be incredibly baffling to a primary care provider or flight physician.[5] It's possible that, in the absence of clear instruction regarding MEB and profiling procedures, primary care providers may underestimate their applicability. Another contributing factor may be the need for military primary care providers to focus on clinical rather than administrative issues, given the pressure they're under to see many patients in a short period of time.

Substance abuse issues also were brought up rarely in consultations in this study. This may reflect the military's ambiguity with respect to alcohol use, as well as its zero tolerance policy for illicit drugs. Both of these factors may have the unintended effect of discouraging service members from honestly reporting their substance use patterns, despite questions from their providers. In addition, many potential users are screened

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out by random drug testing programs and evaluated outside of the primary care setting.

Complex disease management issues were discussed in about one eighth of the consultations. The care of patients seen frequently for chronic physical symptoms or underlying maladaptive personality traits can be very difficult for many primary care clinics to manage. Consultation can help in this task by recommending appropriate referrals and offering tips for overcoming challenging management issues.

In terms of referral patterns and direct psychiatric consultation, the BFPC model seemed to maximize treatment by primary care, prior to psychiatric referral. With the help of BFPC, primary care providers continued to manage care for just over half (51%) of the 131 patients with psychiatric concerns. From an executive standpoint, this could be expected to result in a considerable cost savings.

Overall, the consultation model was well received by both physician and nonphysician primary care providers. Their responses to the anonymous survey suggest that concerns covering the full gamut from diagnosis and workup to biopsychosocial treatment can be addressed by BFPC. Notably, nonphysician providers gave a higher rating to medication management issues than their physician counterparts. This fact is consistent with informal feedback I received from these providers, in which they indicated that BFPC helped expand their armamentarium of medication options and helped them approach their prescribing duties with increased confidence.

Some behavioral health models mimic family medicine, with patients given "mini assessments" by mental health care providers in short appointment slots. Often, these assessments are not comprehensive and, thus, fall short of standards for mental health specialty care established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The medicolegal ramifications of this type of model currently are unknown.

By contrast, the BFPC model uses brief consultation as a gateway to more appropriate referrals, during which the psychiatrist can perform a full biopsychosocial assessment. It should be noted, however, that while this model was considered for a best practice by the Air Force Inspection Agency, it hasn't yet been tested in terms of JCAHO or medicolegal standards.

STUDY LIMITATIONS

A chief limitation of this retrospective review was the lack of patient follow-up regarding actual outcomes. In addition, the BFPC model assumes that the primary care clinic has the appointment availability to follow patients with some frequency. For example, it's not known how effective this consultation model was at helping providers continue to treat their patients whom they might otherwise have referred to civilian mental health care.

Furthermore, this study reflects one air force outpatient clinic; it's unknown whether similar patterns of interaction and consultation would be achieved at tertiary teaching hospitals or at VA or civilian clinics. Although consultations involved patients from the army, coast guard, marines, navy, and PHS, as well as the air force, the ability to generalize these results to primary care clinics in other military services also is unclear. Further research in other federal and nonfederal settings would help clarify the applicability and effectiveness of this model for all venues.

The subjectivity of provider interventions, as well as survey responses, also must be acknowledged. In particular, the rating of specific areas in the survey may reflect personality styles or general appreciation for the consultant rather than actual improvement in these areas. It would be highly beneficial, therefore, to determine whether these findings could be replicated in other settings.

Finally, regarding referral patterns, it's unknown how many patients would have been referred either to the base psychiatrist or to civilian TRICARE providers if this consultation model had not been in use.

BROADER APPLICATION

This retrospective study corroborates the findings of previous studies that indicate psychiatric consultation can be used to benefit primary care. A psychiatrist who enjoys educating providers about the latest concepts in psychiatry while simultaneously learning about advances in primary care can be a welcome addition to a primary care setting—especially when primary care providers need help with the nuances of medication management and other complex issues that involve both medical and mental health expertise. As demonstrated by the topics of consultation noted in this study, having a mental health consultant with a medical background can be invaluable. Moreover, the subjective appreciation by primary care providers for BFPC suggests that this model is well received and may facilitate

ongoing communication between primary and mental health care.

This sort of consultation may be especially advantageous in the DoD and VA. Given the tremendous mental health patient load and the shortage of psychiatrists in these settings, a consultation model similar to BFPC may improve care through patient-specific provider interaction and education. Theoretically, improvement in the appropriateness of referrals should result in more timely care for those with urgent needs, and focused discussion should enhance triage of those with highly specific problems.

From a military standpoint, ongoing consultation between psychiatry and flight medicine and Personnel Reliability Program departments could have a substantially positive impact on force health and readiness, considering the dire medical and military consequences that can result from a sentinel mental health event during an operation. In addition, many military mental health clinics are not staffed to handle the individual psychotherapy or pharmacologic needs of dependents and retirees, yet referring these patients to outside providers can be costly for the DoD. Together with the use of psychosocial group therapy, the BFPC model might help the DoD save money by allowing primary care providers to manage dependent and retiree mental health care with some consultation from the psychiatrist.

At VA facilities with long waits for psychiatric follow-up, a consultation model similar to BFPC might help improve the quality and timeliness of care by enhancing primary care providers' knowledge while decreasing the burden placed on mental health clinics.

This model also may have implications for the civilian sector. In rural areas where patients don't have direct access to psychiatric care, the model could help primary care providers manage more complex psychiatric conditions in their own practices. And by limiting psychiatric referrals to the most severe cases and those that have not responded to appropriate primary care interventions, BFPC could save money for managed care companies.

A number of issues would need to be addressed, though, in order for BFPC to fulfill these promises. In the federal setting, for example, it would be important to come up with a system for documenting workload created for the psychiatrist by consultations. In the nonfederal sector, psychiatrists might be reluctant to make recommendations regarding patients they have not directly assessed unless certain legal issues were resolved. Finally, the creation of a consultation billing code and satisfactory reimbursement rate might make this type of work more attractive to psychiatrists.

The results of this retrospective review suggest that BFPC psychiatric consultation may be uniquely beneficial in addressing diagnostic issues with medical complexities, subtleties of medication management, and biopsychosocial treatment. Follow-up studies testing this model—or a similar one—in various federal and nonfederal settings would be helpful in assessing the most clinically and economically useful ways for psychiatrists to provide primary care consultations. ●

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