Working With Psychotherapists Now Important in Psychiatry

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — In psychiatry, the thinking has changed on working with psychotherapists who lack medical degrees, according to Dr. John Q. Young.

Dr. Young, a psychiatrist with the University of California, San Francisco, said knowing how to collaborate with doctorate- or masters-level psychotherapists is an increasingly important skill.

Years ago, not only was the emphasis on treatment by the medical doctor, but the physician often showed undisguised hostility to other clinicians, Dr. Young said at a meeting on depression research and treatment sponsored by the university. Some psychiatrists framed these issues in ethical terms. For example, a survey of psychiatrists in the 1980s showed that fully two-thirds believed that it was unethical to collaborate with non-MD therapists, he said.

More recent models of interactions between psychiatrists and psychotherapists emphasize relationships that are supervisory, consultative, or collaborative.

In a typical collaborative scenario, the psychiatrist manages the patient's medications while the other clinician—a psychologist, a clinical social worker, or a marriage and family therapist—provides psychotherapy.

Other, more complex scenarios also are possible. For example, while the psychiatrist provides pharmacotherapy, one therapist might provide group dialectical-behavior therapy, another therapist might provide individual therapy, a neurologist might treat the patient's complicated migraines, and a primary care physician or specialist might treat the patient's chronic fibromyalgia pain.

Even the typical scenario sets up complicated triangular patterns of transference and countertransference. Still, Dr. Young offered several tips aimed at making such collaborations pleasant and therapeutically fruitful.

Dr. Young recommended establishing a written or oral contract with the patient and the other clinician at the beginning of therapy. At the Langley Porter Psychiatric Hospital and Clinics, where Dr. Young serves as associate director of the adult psychiatry clinic, psychiatrists use a standard form called "Collaborative Treatment Notice to Patients." This form emphasizes that there is no supervisory relationship between the psychiatrist and the therapist, but that the two will be communicating as necessary about the patient's case.

The notice clarifies that medication-related problems or questions should go to the psychiatrist and that other concerns about treatment should go to the therapist.

One step the psychiatrist can take is to telephone or meet with the psychotherapist early in the patient's treatment, when it's critical to discuss and agree on a diagnosis. In Dr. Young's experience, the psychiatrist gains useful information—and the psychotherapist is pleasantly surprised—if the psychiatrist inquires about the therapist's working diagnosis.

It also is helpful for the psychiatrist and psychotherapist to learn and appreciate each other's focus. "This goes to developing ways of relating beyond our historic tribal conflicts," Dr. Young said. Furthermore, it is in everyone's best interests for the collaborators to understand each other's approach and training, elucidate belief systems around risk management, and be explicit about goals for psychotherapy and pharmacotherapy.

Agreeing on the type and frequency of routine and emergent communication is an important part of the collaborative process. "Our minimum standard for our clinicians is to call when there's any change in clinical status or treatment and to ask that the other collaborators do the same," Dr. Young said. "Some of us practice what I call 'turbo-collaboration,' where a psychiatrist tries to call after each visit with a message summarizing what the patient's status was and any change in meds."

Dr. Young stated that he had no conflicts of interest related to his presentation. ■

Charter Sets Rules for Physician Ratings

BY MARY ELLEN SCHNEIDER
New York Bureau

Under an agreement among physicians, consumers, employers, and large insurers, some health plans have agreed to have their physician rating systems audited by independent experts.

The announcement comes after physicians across the country questioned the methods used by health plans to produce performance ratings for consumers.

Under the voluntary agreement, health plans would disclose their rating methods. In addition, physicians would have a chance to review their performance data and challenge it prior to publication.

"Having that transparency is a huge change," said Dr. Douglas Henley, executive vice president of the American Academy of Family Physicians, which is supporting the agreement, known as the Patient Charter for Physician Performance Measurement, Reporting, and Tiering Programs.

Giving physicians a chance to ensure that the data is accurate makes the process fair, he said. It's also beneficial for consumers who will be able to better rely on the information provided by their health plan, Dr. Henley said.

The project was led by the Consumer-Purchaser Disclosure Project, a coalition of consumer, labor, and employer organizations that support publicly reported health performance information.

Other principles of the Patient Charter state that the measures should aim to assess whether care is safe, timely, effective, equitable, and patient centered. The measures used should also be based on national standards, preferably those endorsed by the National Quality Forum.

This agreement provides a foundation for physicians to build on, said Dr. David C. Dale, president of the American College of Physicians, another supporter. Now when any health plan establishes a physician rating system, physicians can ask whether it is standardized and how it stacks up against the requirements of the Patient Charter, he said.

The Patient Charter also has the support of the American Medical Association, the American College of Cardiology, and the American College of Surgeons.

And some heavy hitters in the insurance industry have agreed to abide by the principles of the charter, including trade group America's Health Insurance Plans (AHIP), as well as Aetna, Cigna, UnitedHealthcare, and WellPoint.

Other health plans are likely to follow suit, said Susan Pisano, AHIP spokeswoman. Third-party review of rating systems and allowing physicians to review and challenge data before they become public will likely become the industry standard, she said. ■

Medical Home Concept Now Closer to Reality

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — The concept of a medical home is one step closer to reality for Medicare patients, after it received strong backing from the Medicare Payment Advisory Commission.

All 17 commissioners present at the meeting in April voted to urge Congress to instruct the Centers for Medicare and Medicaid Services to develop a large pilot study of medical homes for Medicare beneficiaries. The recommendation will be included in MedPAC's June report to Congress.

Most of the commissioners also voted to adjust the Medicare fee schedule to increase payment for primary care, which MedPAC has deemed as undervalued at previous meetings.

The medical home concept has been advanced by the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics. A demonstration project is authorized under the Medicare program, but the commissioners said that a larger pilot with clear thresholds could accelerate the evaluation process, and could easily be discontinued or expanded.

The commissioners compiled a wish list of criteria for a medical home, including the ability to provide primary care, use information technology for clinical decision support, conduct care management, offer 24-hour communication with patients, maintain up-to-date records of patients' advance directives, and operate a formal quality improvement program. Also, beneficiaries should agree to adhere to medical home principles by respecting the idea that someone is in charge of coordinating their care, and communicating with the physician when they seek care elsewhere.

There was some debate over whether patients should be allowed to access other providers without a referral, which is permitted under current fee-for-service Medicare. Most commissioners wanted some restrictions, or at least a way to track when patients see specialists, to facilitate assessment of the program's success or failure.

The medical home would not be limited to primary care physicians; specialists likely would be able to fulfill criteria for participation, according to the commission's vision.

The program would cost $50-250 million in the first year, and cost less than $1 billion over the first 5 years, MedPAC staffers estimated. The estimate included monthly fees to medical homes, but not anticipated savings, said MedPAC staffer Christine Boccuti.

Dr. Francis Jay Crosson, a commissioner and senior medical director of Permanente Federation in Oakland, called the proposal a "significant evolution" from what had been presented to the panel in 2007. "And I think it's a good evolution," he said.

"This is a very exciting recommendation," said Commissioner Jack Ebeler, a health policy consultant in Reston, Va. Promotion of the medical home approach is a direct way to reform the health care delivery system, he added.

Commissioners also said that the medical home recommendation dovetailed with MedPAC's support of increased pay for primary care services.

An adjustment to the fee schedule is "long overdue," said Dr. Ronald Castellanos, a commissioner and urologist in private practice in Ft. Myers, Fla. Increased pay might lure more residents into primary care, and help those currently practicing to stay in the workplace, he said.

The commissioners debated how the CMS could determine which physicians or other health providers—such as nurse practitioners—would receive the update. MedPAC staff presented the increase as budget neutral, which made some panelists uneasy.

Dr. Nicholas Wolter of the Billings (Mont.) Clinic, suggested that the increase be made without trying to maintain budget neutrality. Dr. Karen Borman, professor of surgery at the University of Mississippi, Jackson, expressed concern that rewarding primary care could end up hurting other physicians.

"I have some philosophical problems here," said Dr. Borman, adding that primary care was not always linked with a traditional primary care physician. Dr. Borman ended up voting against the recommendation for increased pay for primary care. ■