The Evolving Role of Psychiatry in the Era of Health Care Reform

Lori Raney, MD
Medical Director Axis Health System
Chair, APA Workgroup on Integrated Care
September 26, 2014

Faculty Disclosure

- Lori Raney, MD has no financial relationships to disclose relating to the subject matter of this presentation.

Learning Objectives

- Discuss the core principles of effective collaborative care and their contribution to evidence-based practice
- Describe the roles of the core team members on a collaborative care team and their interactions
- Recognize the cultural differences between primary care and behavioral health and how to overcome obstacles

IMPACT Study (2002)

Wall Street Journal, September 2013

A4 | Wednesday, September 25, 2013 THE WALL STREET JOURNAL.

U.S. NEWS

Mental-Health Care at the Doctor's Office

Providers Take Integrated Approach, With Patient Numbers Set to Jump Under New Law and Psychiatrists in Short Supply

By Melinda Beck

Seattle psychiatrist Anna Ratcliff oversees mental-health care for nearly 500 patients—most of whom she will never meet.

As the consulting psychiatrist for four primary-care practices, Dr. Ratcliff confers weekly with 10 care managers who follow the patients closely, provide counseling and chart their progress in electronic registries. She helps devise treatment plans and suggests changes for those who aren't improving.

"I get to touch so many more lives than I would if I were seeing these patients in person," she said.

Dr. Ratcliff's practice is part of a burgeoning effort to integrate psychiatric care into pri-

The New State Of Health Care

Body and Mind

Who needs, gets, gives care

25% of U.S. adults experience a mental-health issue in a given year

60% of them receive no treatment

68% of adults with a mental-health disorder have at least one medical condition

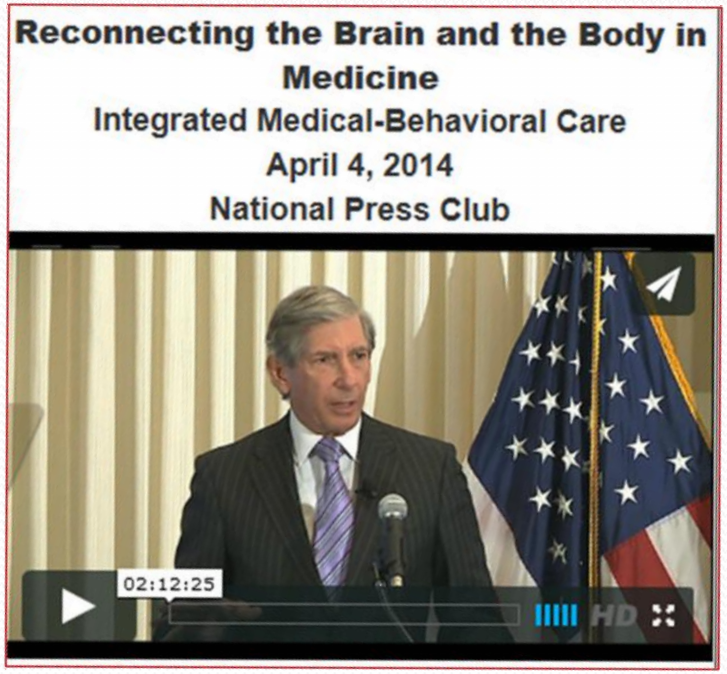
29% of those with a medical condition have a mental-health issue

50% of care for mental-health disorders is delivered by primary-care providers

66% of visits to family physicians involve stress-related symptoms

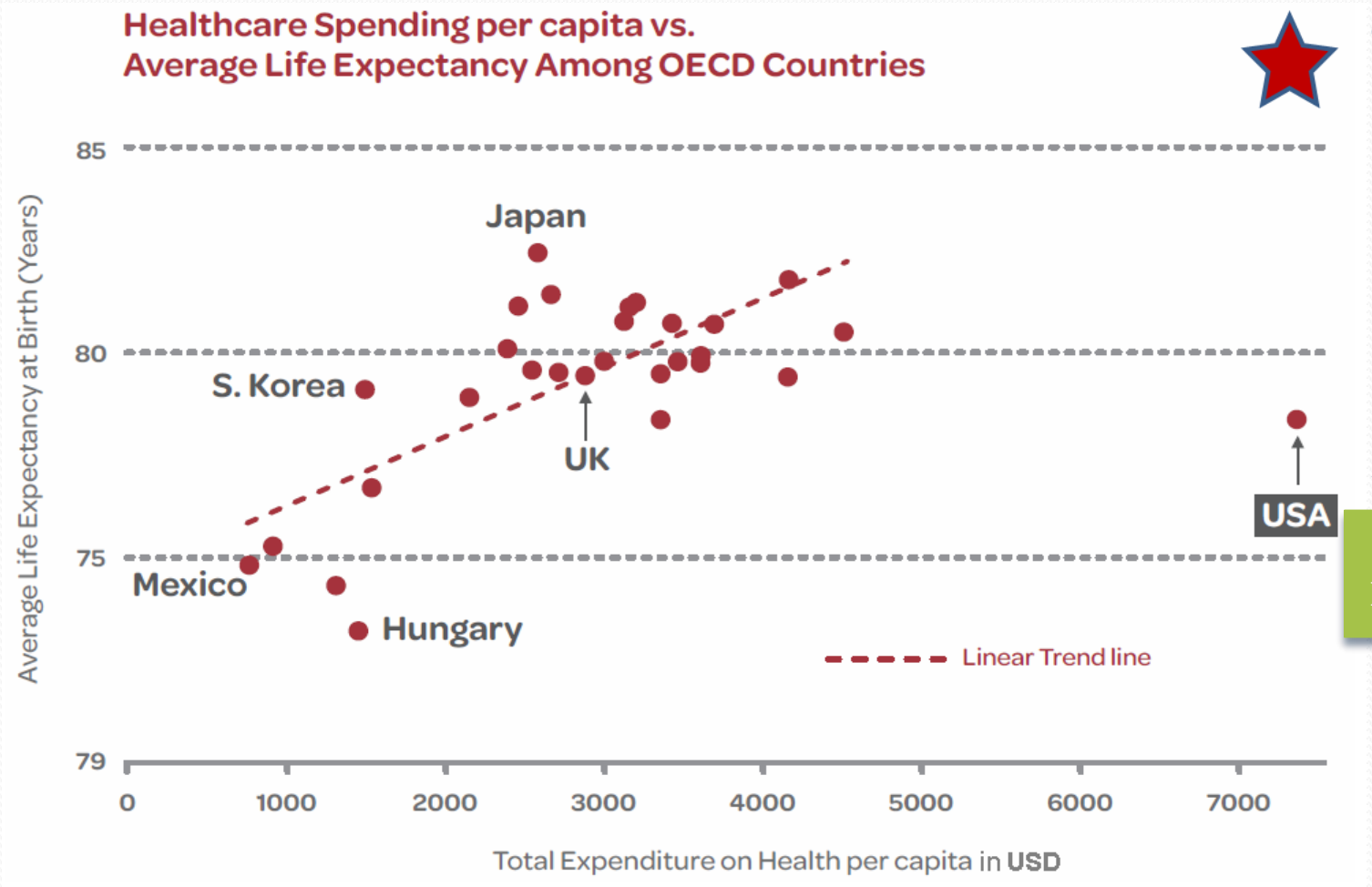
Dr. Thomas Gallarch with patient Magali King, who

April 2014



IMPACT study published 2002

Healthcare Spending



OECD 2009. www.oecd.org. Accessed July 19, 2014.

Annual Cost of Care

Patient Groups	Annual Cost of Care ($)	Illness Prevalence (%)	Percent with Comorbid Medical Condition*	Annual Cost with Mental Condition ($)	Percent Increase with Mental Condition
All insured	2920		10-15		
Arthritis	5220	6.6	36	10,710	94
Asthma	3730	5.9	35	10,030	169
Cancer	11,650	4.3	37	18,870	62
Diabetes	5480	8.9	30	12,280	124
CHF	9770	1.3	40	17,200	76
Migraine	4340	8.2	43	10,810	149
COPD	3840	8.2	38	10,980	186

Total Population

Common Chronic Medical Illnesses with Comorbid Mental Condition "Value Opportunities"

***Approximately 10% receive evidence-based mental condition treatment.**

Cartesian Solutions, Inc.™--consolidated health plan claims data.

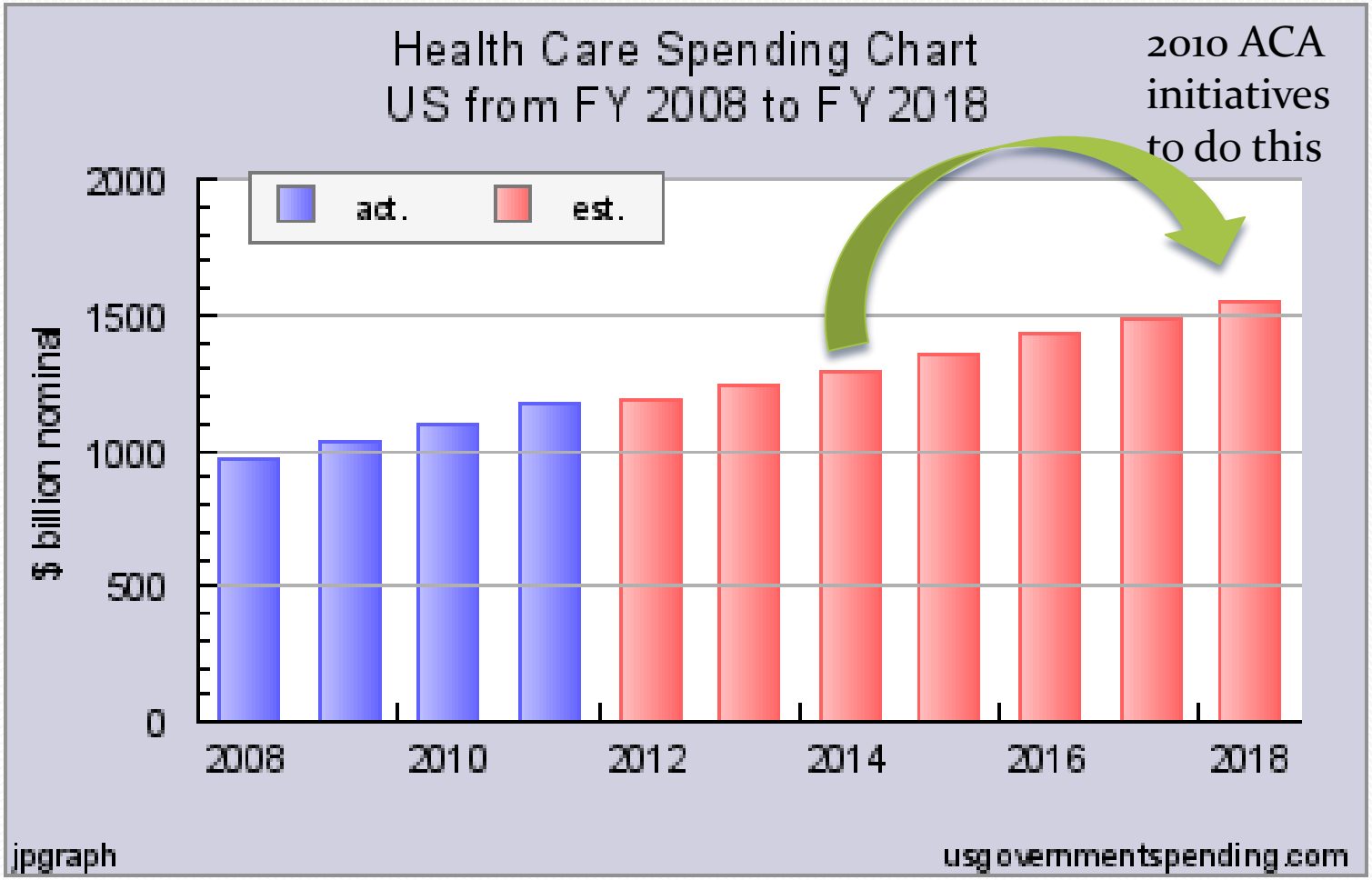
CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease.

APA Milliman Report

- Large claims database; included Medicaid, Medicare, commercial insurers in 2010
- 4 categories
  - No MH/SUD
  - Non-SMI MH/SUD
  - SMI
  - SUD
- Patients with treated MH/SUD conditions increased overall healthcare costs 2 to 3 times ($400 PMPM vs $1000 PMPM)
- Cost is from facility-based charges: medical/surgical, ICU, ER

MH/SUD = no mental health/substance use disorder diagnoses; SMI = serious mental illness; SUD = substance use disorder; PMPM = per member per month; ICU = intensive care unit; ER = emergency room.
www.psych.org.

“Bending the Cost Curve”

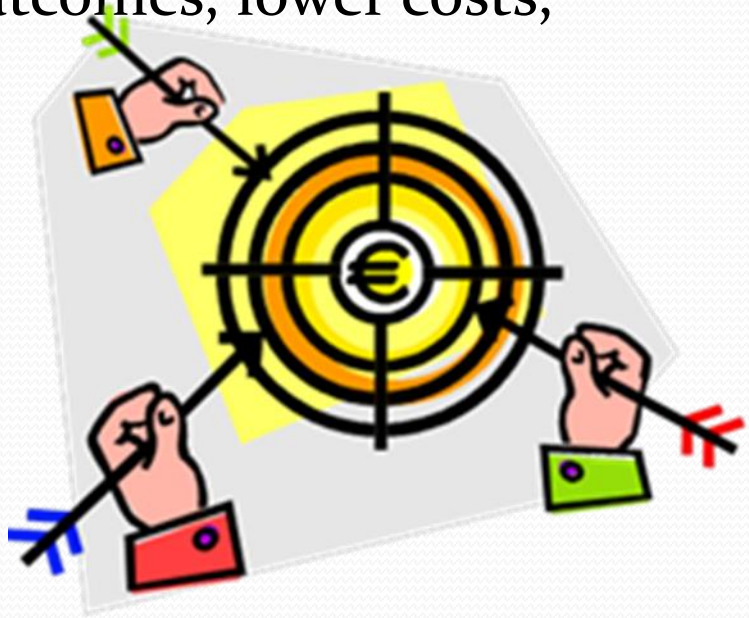


ACA = Affordable Care Act.

www.usgovernmentspending.com. Accessed July 19, 2014.

ACA 2010

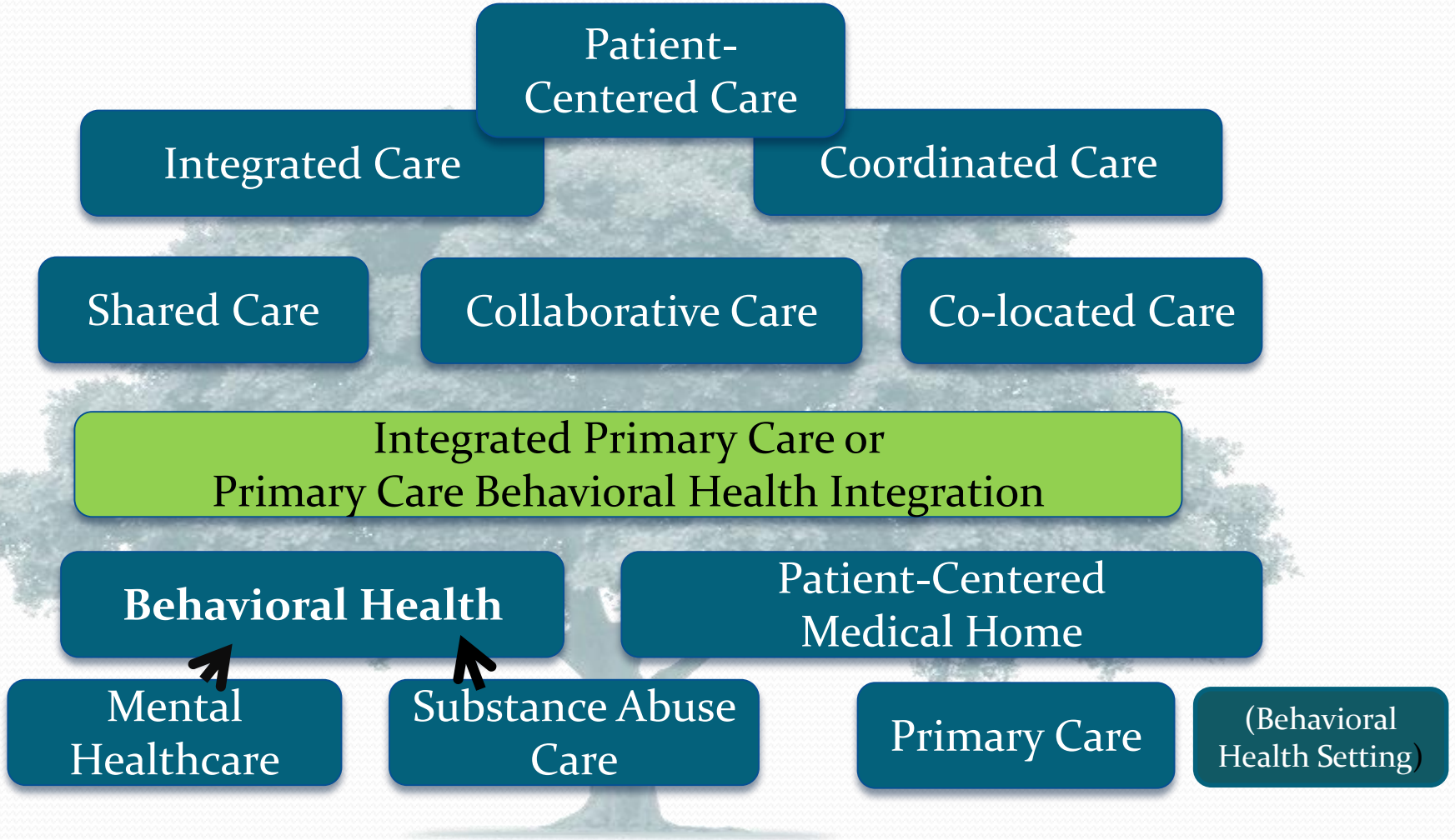
- **Insurance expansion – 60 million more covered**
- **Triple Aim Initiatives:** better outcomes, lower costs, better experience of care
  - Innovation grants
    - Collaborative care
    - Payment structures
  - Behavioral Health Homes: SPAs
  - Expand CHCs
  - Expand PBHCI grantee sites



SPAs = State Plan Amendments; CHC = community health center; PBHCI = Primary and Behavioral Health Care Integration.

US Department of Health and Human Services. www.hhs.gov/healthcare/rights/. Accessed July 19, 2014.

Lexicon for Integrated Care



Adapted from: Peek CJ. A family tree of related terms used in behavioral health and primary care integration. http://integrationacademy.ahrq.gov/lexicon. Accessed July 19, 2014.

Definition: AHRQ 2013

- The care that results from a practice team of primary care and behavioral health clinicians, working with patients and families, using a **systematic and cost-effective** approach, to provide patient-centered care for a **defined population**

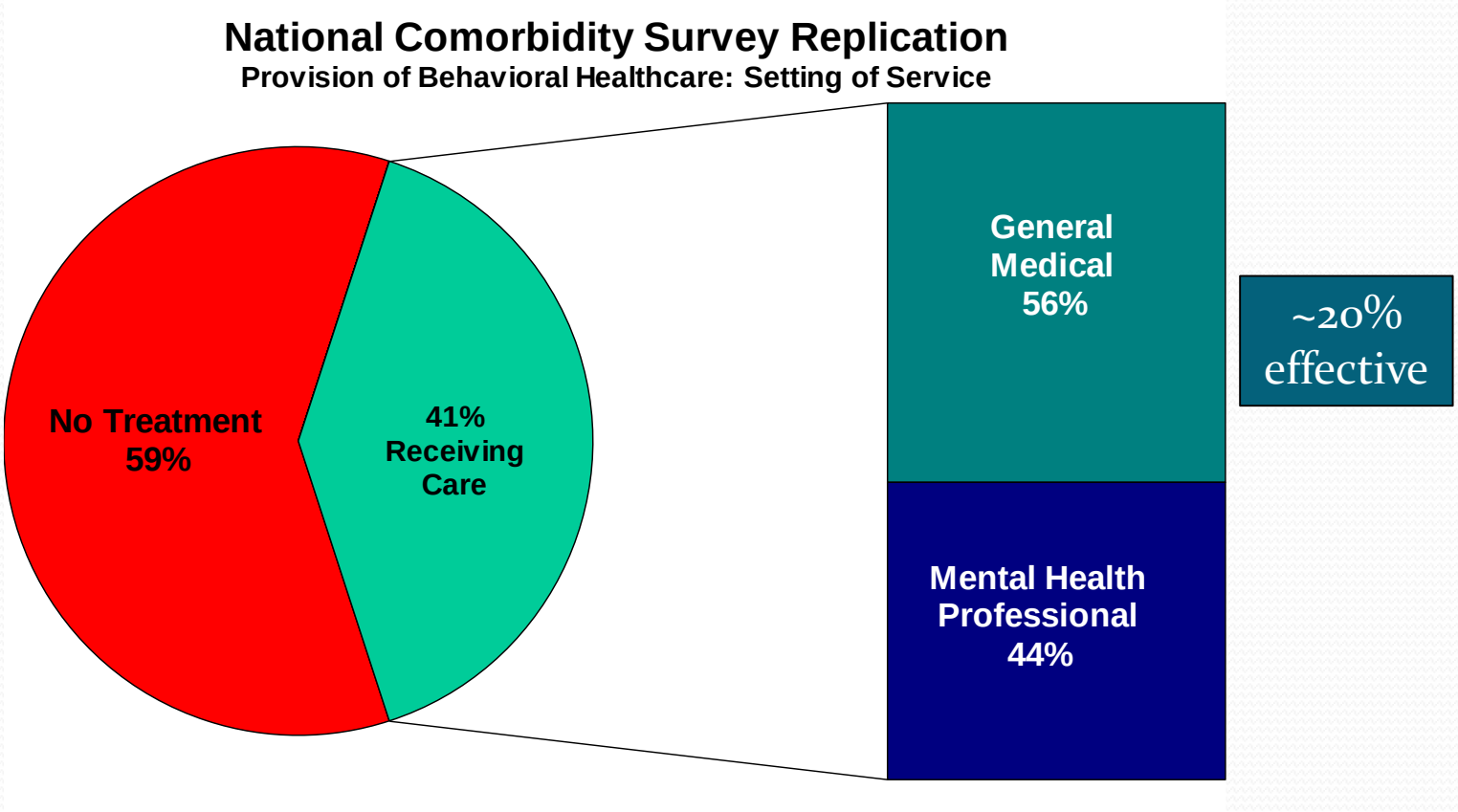
AHRQ = Agency for Healthcare Research and Quality.
Lexicon Project. http://integrationacademy.ahrq.gov/lexicon. Accessed July 19, 2014.

Levels of Integration

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

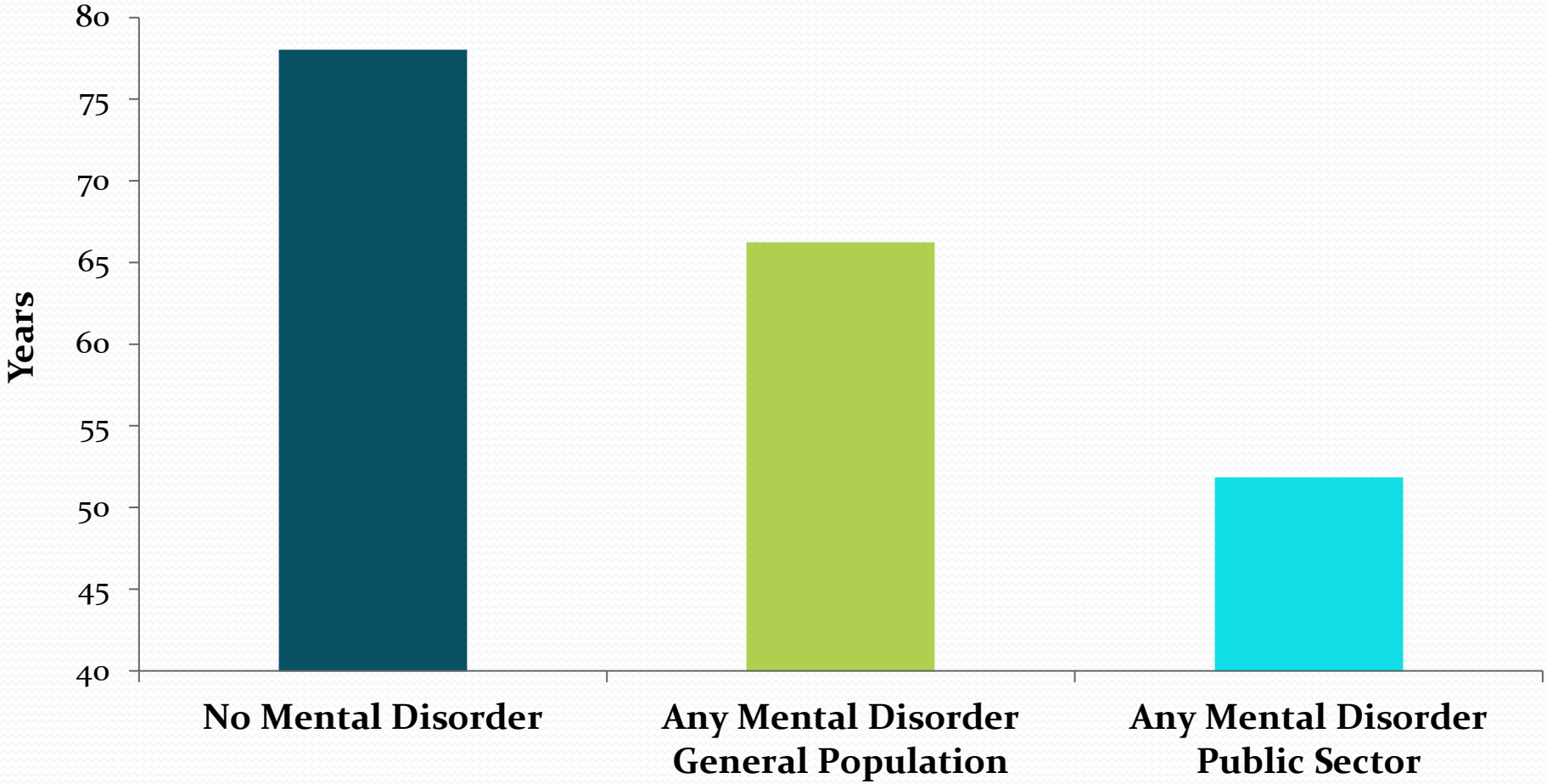
Center for Integrated Health Solutions. http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf. Accessed July 19, 2014.

Primary Care is the "De Facto" Mental Health System



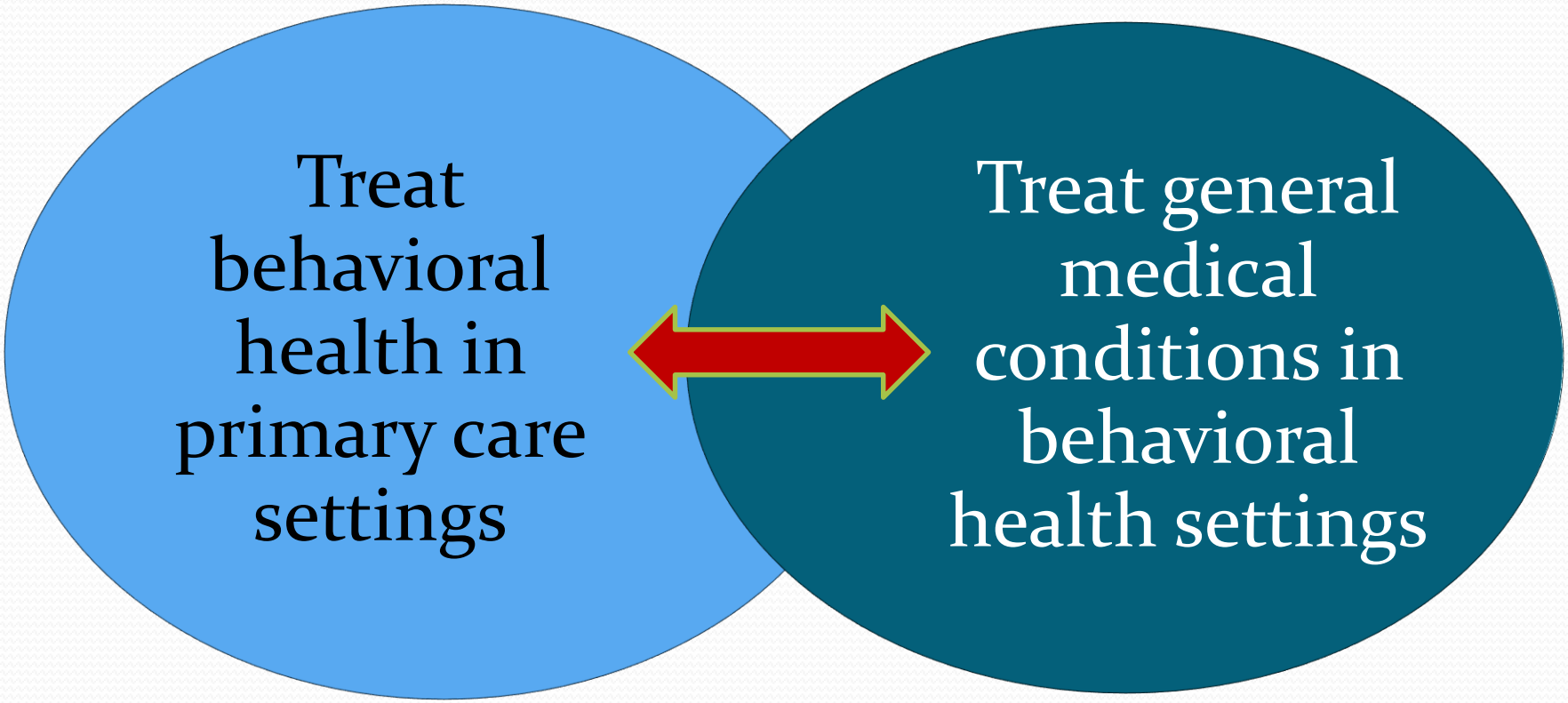
Wang P, et al. *Arch Gen Psychiatry*. 2005;62(6):629-640.

Life Span with and without Mental Disorders

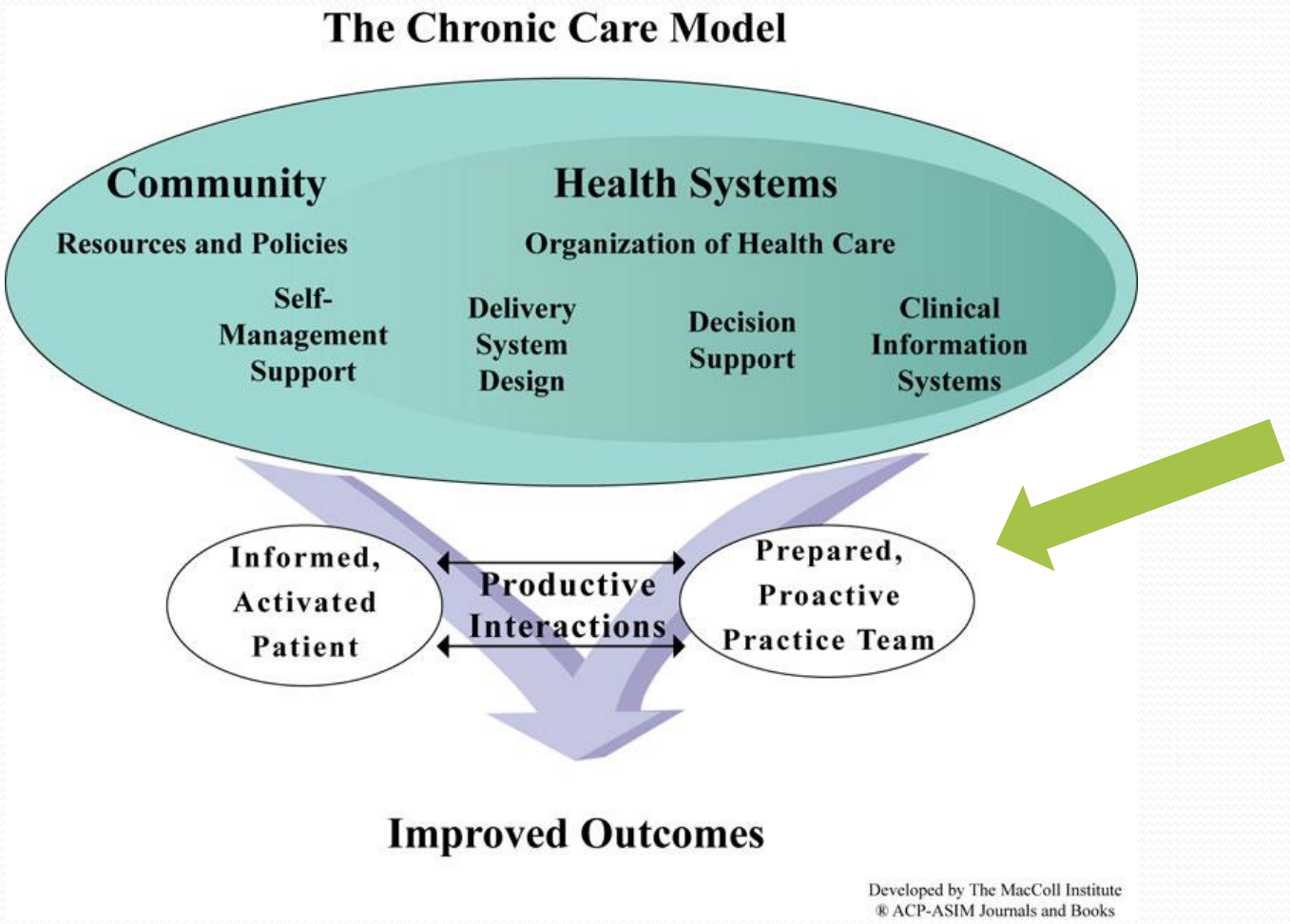


Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604

Range of Opportunities



Wagner Chronic Care Model: 1990s



The Chronic Care Model. www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2. Accessed July 19, 2014.

Collaborative Care Model

Informed, Activated Patient

Effective Collaboration

PCP supported by Behavioral Health Care Manager

Measurement-Based Stepped Care

Practice Support

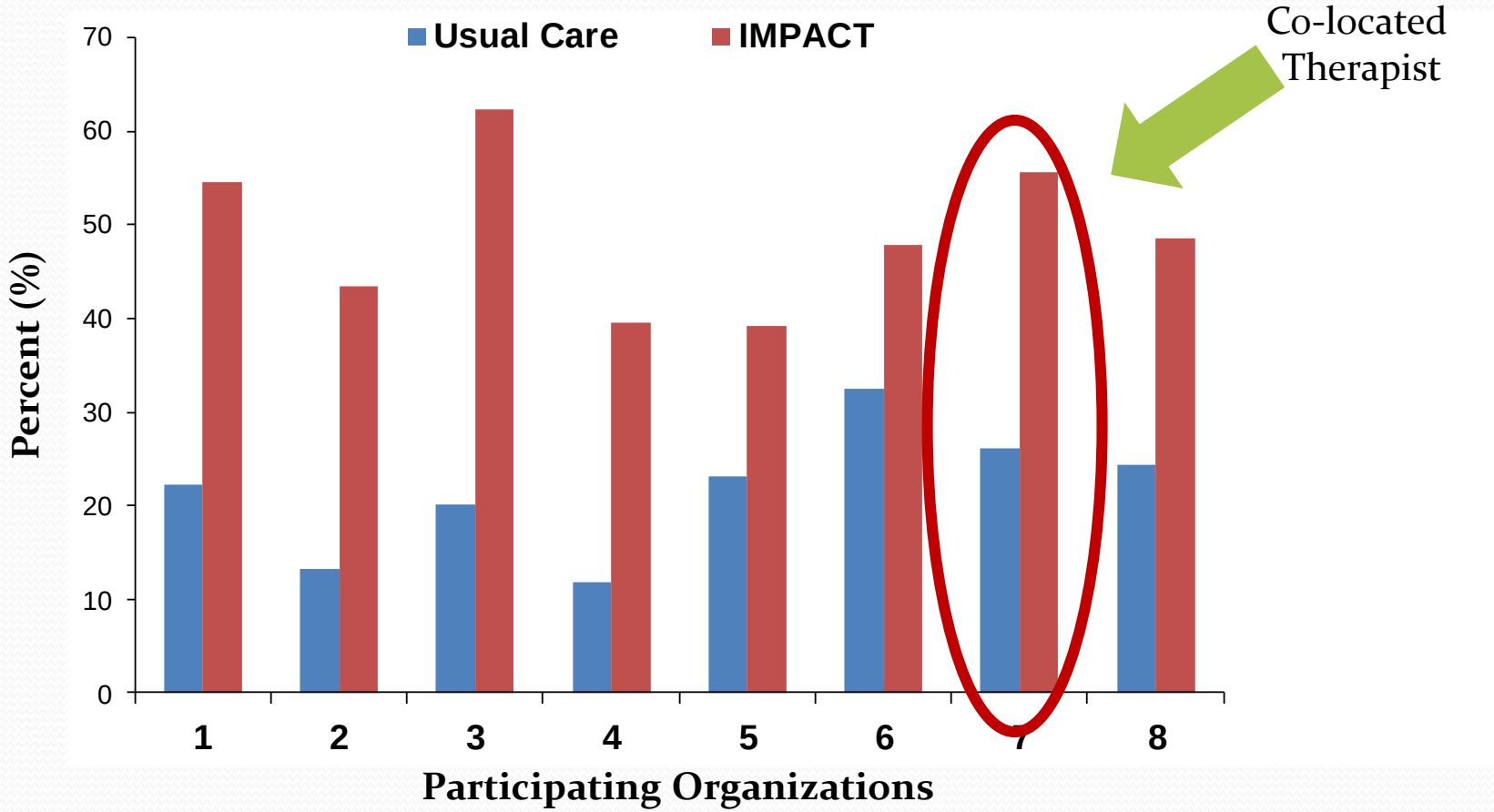
Caseload-Focused psychiatric consultation

Registry Review

IMPACT. https://impact-uw.org/about/key.html. Accessed July 19, 2014.

Doubles Effectiveness of Care for Depression

50% or greater improvement in depression at 12 months



Unützer J, et al: Collaborative-care management of late-life depression in the primary care setting. JAMA 288(22):2836–2845, 2002

Evidence Base for IMPACT Model

- Over 80 RCTs
  - Archer J, et al. Collaborative care for people with depression and anxiety. *Cochrane Database Syst Rev.* 2012;10:CD006525. **79 RCTs**
  - Community Preventive Services Task Force. Recommendation from the community preventive services task force for use of collaborative care for the management of depressive disorders. *Am J Prev Med.* 2012;42(5):521-524. **69 RCTs**
  - Gilbody S, et al. Collaborative care for depression in primary care (US and Europe). *Arch Intern Med.* 2006;166(21):2314-2321. **37 RCTs**

RCTs = randomized controlled trials.

Long-Term Cost Savings

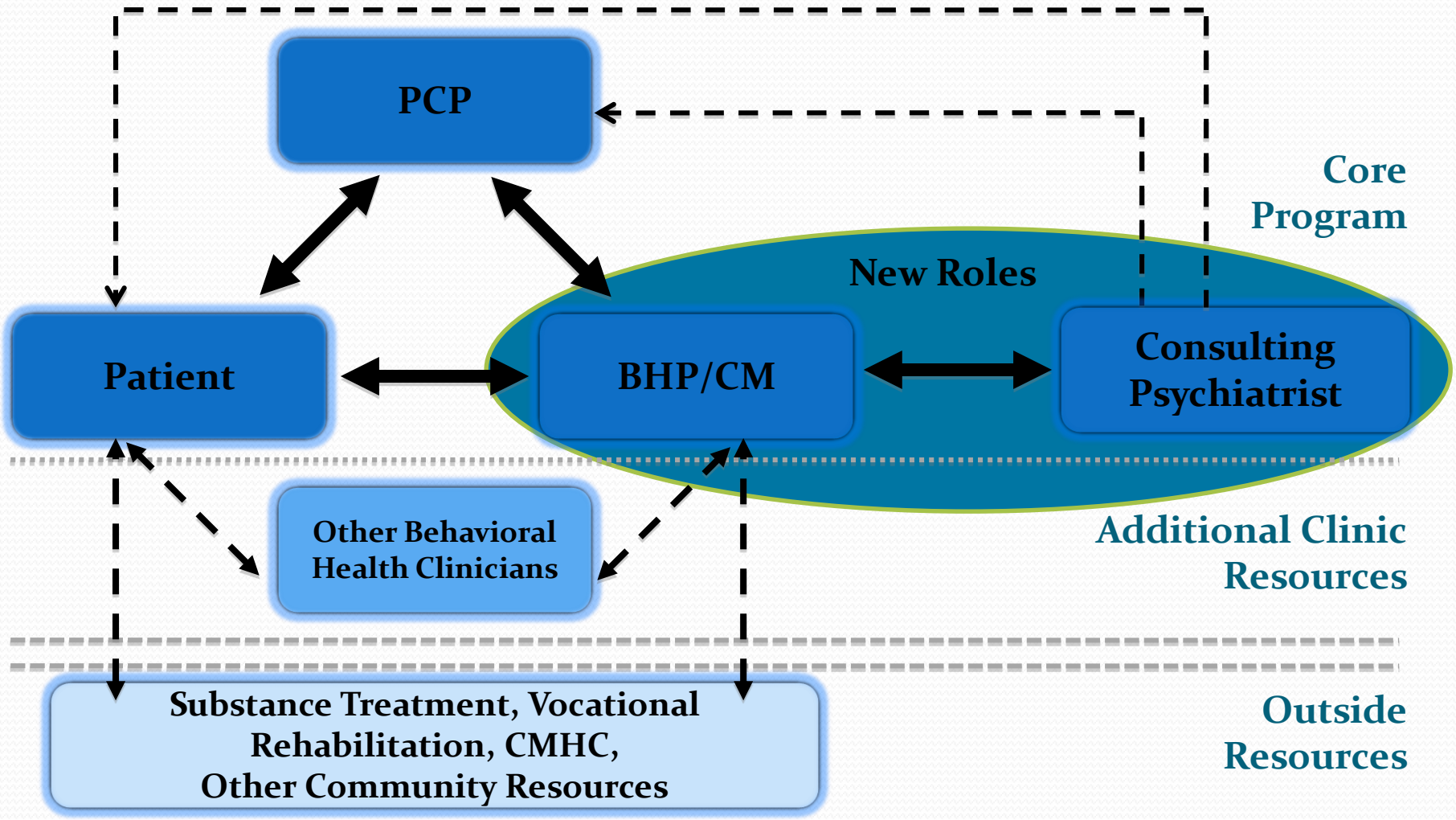
Cost Category	4-Year Costs ($)	Intervention Group Costs ($)	Usual Care Group Costs ($)	Difference ($)
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7284	6942	7636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8452	7179	9757	-2578
Inpatient mental health/ substance abuse costs	114	61	169	-108
Total healthcare cost	31,082	29,422	32,785	-$3363

Savings

ROI
$6.50 : $1.00

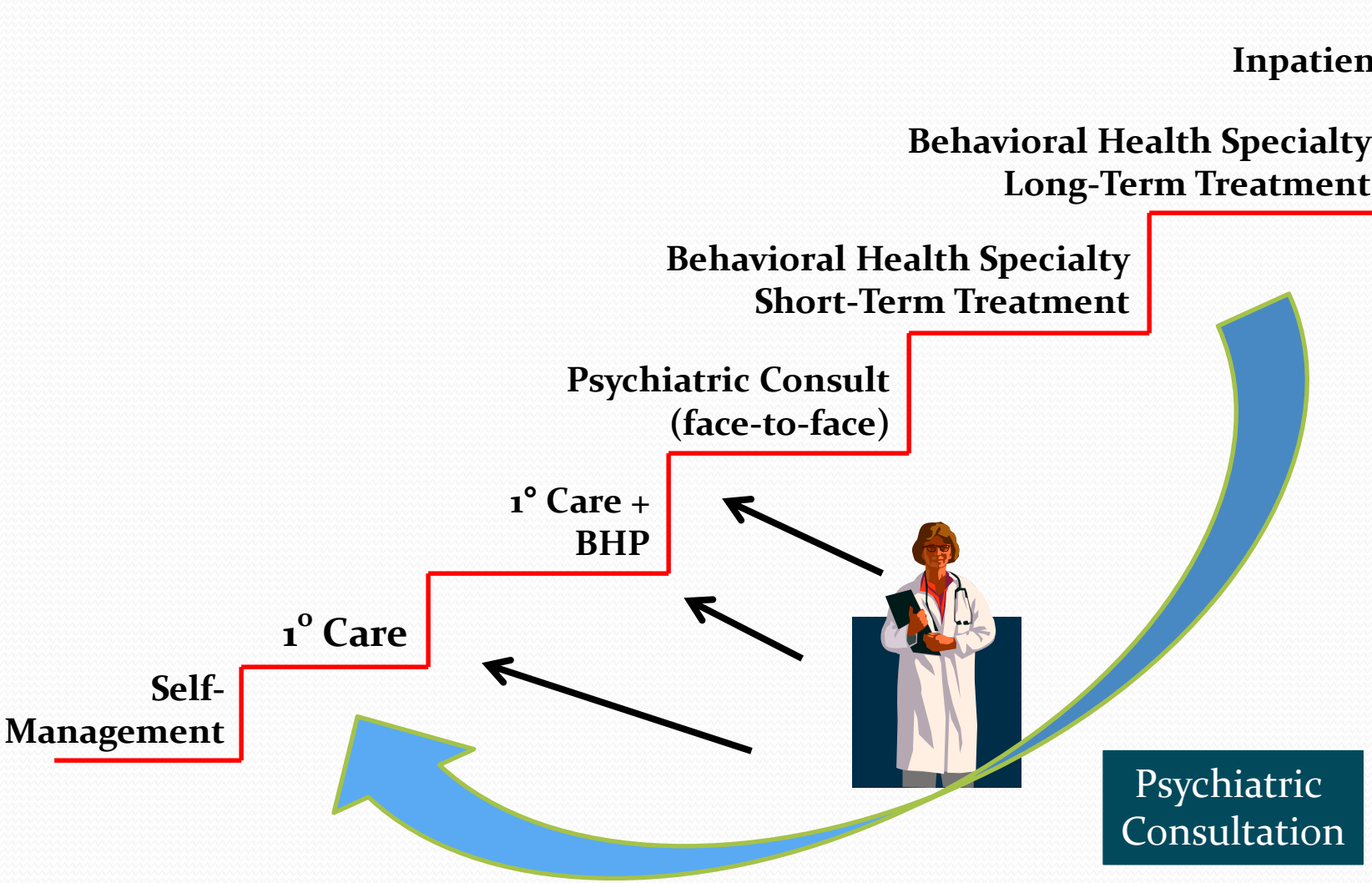
Unützer J, et al. *Am J Manag Care*. 2008;14(2):95-100.

Collaborative Team Approach



PCP = primary care provider; BHP = behavioral health provider; CM = care manager; CMHC = community mental health center. AIMS uwaims.edu

Stepped Care Model: A Continuum of Care



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE:

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
TOTAL:			15	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

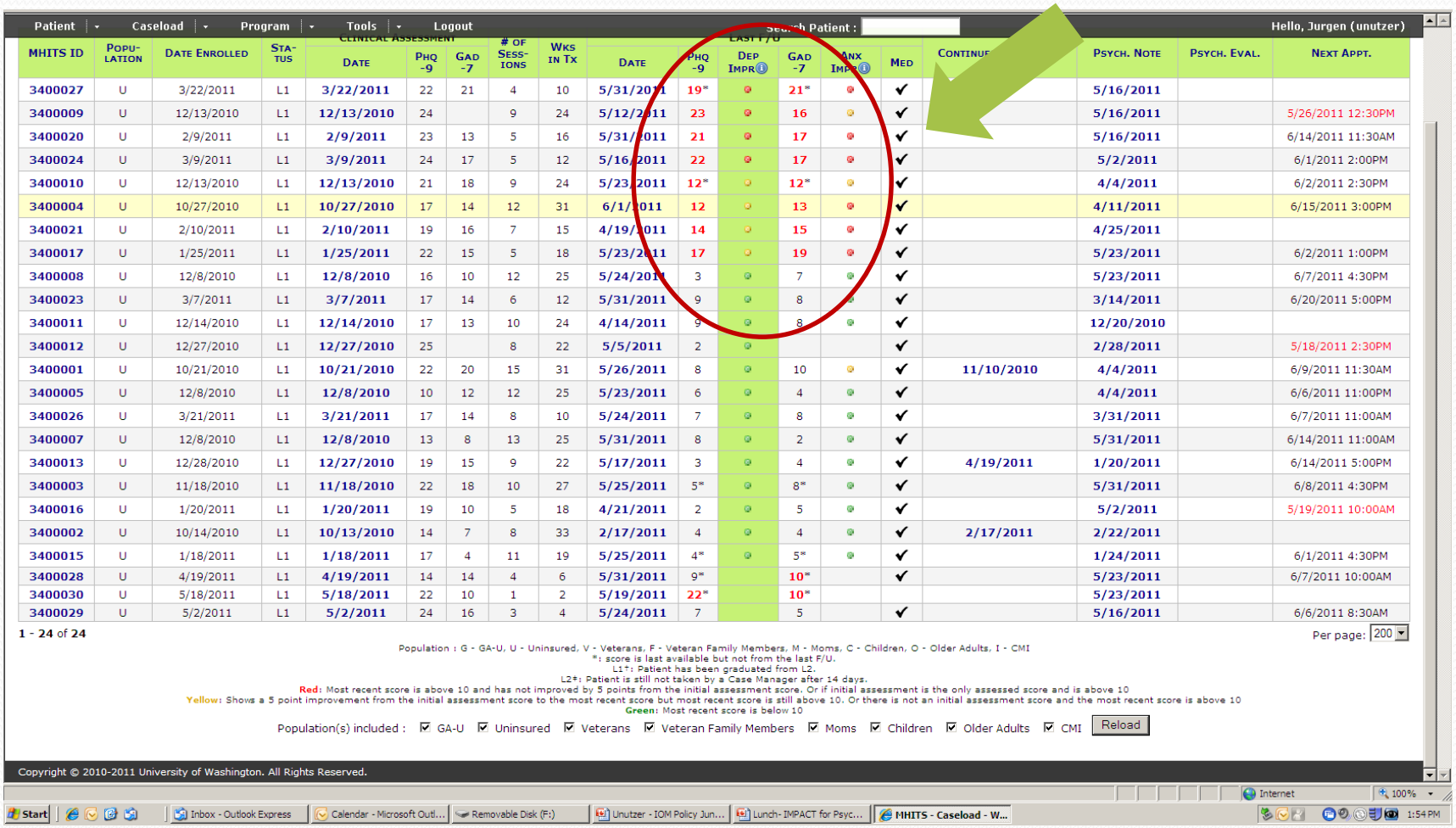
Score > 9

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult ✓
- Very difficult
- Extremely difficult

PHQ-9 = Patient Health Questionnaire.

Systematic Caseload Review



Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment Date	PHQ -9	GAD -7	# of Sess-ions	Wks in Tx	Last F/U Date	PHQ -9	Dep Impr	GAD -7	Anx Impr	Med	Continue	Psych. Note	Psych. Eval.	Next Appt.
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓		5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/12/2011	23		16		✓		5/16/2011		5/26/2011 12:30PM
3400020	U	2/9/2011	L1	2/9/2011	23	13	5	16	5/31/2011	21		17		✓		5/16/2011		6/14/2011 11:30AM
3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/16/2011	22		17		✓		5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓		4/4/2011		6/2/2011 2:30PM
3400004	U	10/27/2010	L1	10/27/2010	17	14	12	31	6/1/2011	12		13		✓		4/11/2011		6/15/2011 3:00PM
3400021	U	2/10/2011	L1	2/10/2011	19	16	7	15	4/19/2011	14		15		✓		4/25/2011		
3400017	U	1/25/2011	L1	1/25/2011	22	15	5	18	5/23/2011	17		19		✓		5/23/2011		6/2/2011 1:00PM
3400008	U	12/8/2010	L1	12/8/2010	16	10	12	25	5/24/2011	3		7		✓		5/23/2011		6/7/2011 4:30PM
3400023	U	3/7/2011	L1	3/7/2011	17	14	6	12	5/31/2011	9		8		✓		3/14/2011		6/20/2011 5:00PM
3400011	U	12/14/2010	L1	12/14/2010	17	13	10	24	4/14/2011	9		8		✓		12/20/2010		
3400012	U	12/27/2010	L1	12/27/2010	25		8	22	5/5/2011	2				✓		2/28/2011		5/18/2011 2:30PM
3400001	U	10/21/2010	L1	10/21/2010	22	20	15	31	5/26/2011	8		10		✓	11/10/2010	4/4/2011		6/9/2011 11:30AM
3400005	U	12/8/2010	L1	12/8/2010	10	12	12	25	5/23/2011	6		4		✓		4/4/2011		6/6/2011 11:00PM
3400026	U	3/21/2011	L1	3/21/2011	17	14	8	10	5/24/2011	7		8		✓		3/31/2011		6/7/2011 11:00AM
3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓		5/31/2011		6/14/2011 11:00AM
3400013	U	12/28/2010	L1	12/27/2010	19	15	9	22	5/17/2011	3		4		✓	4/19/2011	1/20/2011		6/14/2011 5:00PM
3400003	U	11/18/2010	L1	11/18/2010	22	18	10	27	5/25/2011	5*		8*		✓		5/31/2011		6/8/2011 4:30PM
3400016	U	1/20/2011	L1	1/20/2011	19	10	5	18	4/21/2011	2		5		✓		5/2/2011		5/19/2011 10:00AM
3400002	U	10/14/2010	L1	10/13/2010	14	7	8	33	2/17/2011	4		4		✓	2/17/2011	2/22/2011		
3400015	U	1/18/2011	L1	1/18/2011	17	4	11	19	5/25/2011	4*		5*		✓		1/24/2011		6/1/2011 4:30PM
3400028	U	4/19/2011	L1	4/19/2011	14	14	4	6	5/31/2011	9*		10*		✓		5/23/2011		6/7/2011 10:00AM
3400030	U	5/18/2011	L1	5/18/2011	22	10	1	2	5/19/2011	22*		10*				5/23/2011		
3400029	U	5/2/2011	L1	5/2/2011	24	16	3	4	5/24/2011	7		5		✓		5/16/2011		6/6/2011 8:30AM

1 - 24 of 24 — Per page: 200

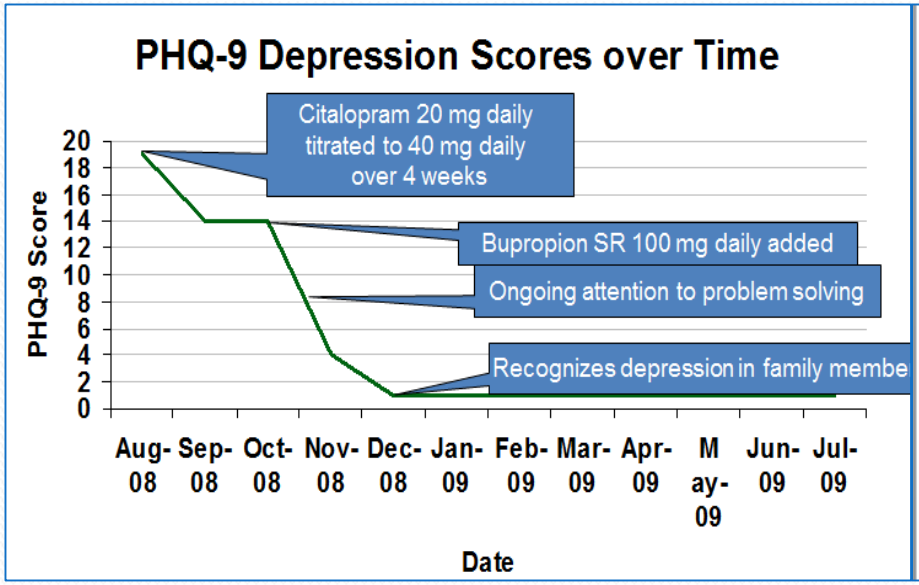
Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1†: Patient has been graduated from L2.
L2*: Patient is still not taken by a Case Manager after 14 days.
Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10
Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

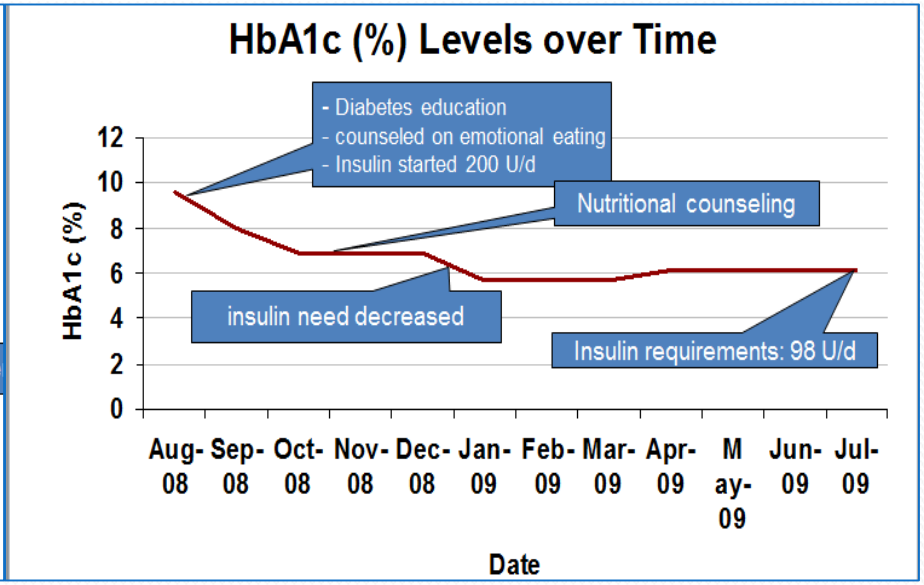
Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... | Internet | 100% | 1:54 PM

AIMS Center: http://aims.uw.edu/. Accessed July 19, 2014.

TEAMcare: Concurrent Treatment





- **Diabetes nurse educators**
- **Caseload supervision**
  - **Depression: psychiatrist**
  - **Diabetes and CAD: family doctor**
  - **Email to diabetologist for complex cases**

HbA1c = hemoglobin A1c; CAD = coronary heart disease.
Courtesy Wayne Katon, Elizabeth Lin – University of Washington

TEAMcare Outcomes

Depression
HbA1c
SBP
LDL

All Improved!

COST SAVINGS:
$600 to $1100 per patient

SBP = systolic blood pressure.
Katon WJ, Lin EH, Von Korff M, et al.: Collaborative care for patients with depression and chronic illnesses. N Engl J Med 363:2611-2620, 2010

How Well Does it Work with Other Disorders?

- Anxiety: good evidence; CALM study
- Bipolar disorder: only 1/3 improve
- Psychotic illnesses - unknown
- SUDs - unknown
- Posttraumatic stress disorder - unknown
- Children: Hilt, Sarvet, Sargent – Pediatric Access Line programs

Roy-Byrne et al. Delivery of Evidence-based treatment of multiple anxiety disorders in primary care. JAMA. 2010;303(19):1921-1928
Cerimele JM, et al. Bipolar Disorder in Primary Care: Psychiatric Services in Advance, April 15, 2014; doi: 10.1176/appi.ps.201300374

Core Principles

Patient-Centered Care Teams

- Team-based care: effective collaboration between PCPs and BHPs
- Nurses, social workers, psychologists, psychiatrists, licensed counselors, pharmacists, and medical assistants can all play an important role

Population-Based Care

- Behavioral health patients tracked in a registry: no one "falls through the cracks;" population-based screening

Measurement-Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient
- Treatments are actively changed until the clinical goals are achieved

Evidence-Based Care

- Treatments used are "evidence-based," having credible research evidence

AIMS Center. http://aims.uw.edu/collaborative-care/principles-collaborative-care. Accessed July 19, 2014.

Extending Psychiatric Expertise to Larger Populations

Caseload-focused psychiatric consultation supported by a CM

Better access

- PCPs get input on their patients' behavioral health problems within a days/a week vs months
- Focuses in-person visits on the most challenging patients

Regular Communication

- Psychiatrist has regular (weekly) meetings with a CM
- Reviews all patients who are not improving and makes treatment recommendations

More patients covered by one psychiatrist

- Psychiatrist provides input on 10–20 patients in a half day as opposed to 3-4 patients

"Shaping over time"

- Multiple brief consultations
- More opportunity to "correct the course" if patients are not improving

CM = care manager.

Psychiatric Consultant Daily Tasks

- Clinical consultation with Behavioral Health Providers (BHPs)
- Telephonic/email/text consultation to PCPs and BHPs - “curbsides”
- Track and oversee panels and clinical outcomes
- Suggest treatment plan changes – “intensification of treatment” in real time, treat to target
- Refer to higher level of care if needed – stepped care
- Consultation notes based on discussion with BHP, chart review, direct evaluation
- On-site clinic visits: scheduled or prn
- Co-visits with PCPs and BHPs
- Education: every consult presents an opportunity with PCP and BHP
- Insure adherence to the model, prevent “regression to co-location”

PCPs: Your Offer

"You can do this, I'm here for you."

"I've got your back."

- Go beyond first-line treatment and/or treat something not comfortable with
- Do this without specialty referral to psychiatry
- Educate, educate – provide algorithms, articles
- Nudge them along while providing "unprecedented support"
- YOU must be readily accessible for this to work

Working with BHPs/CMs

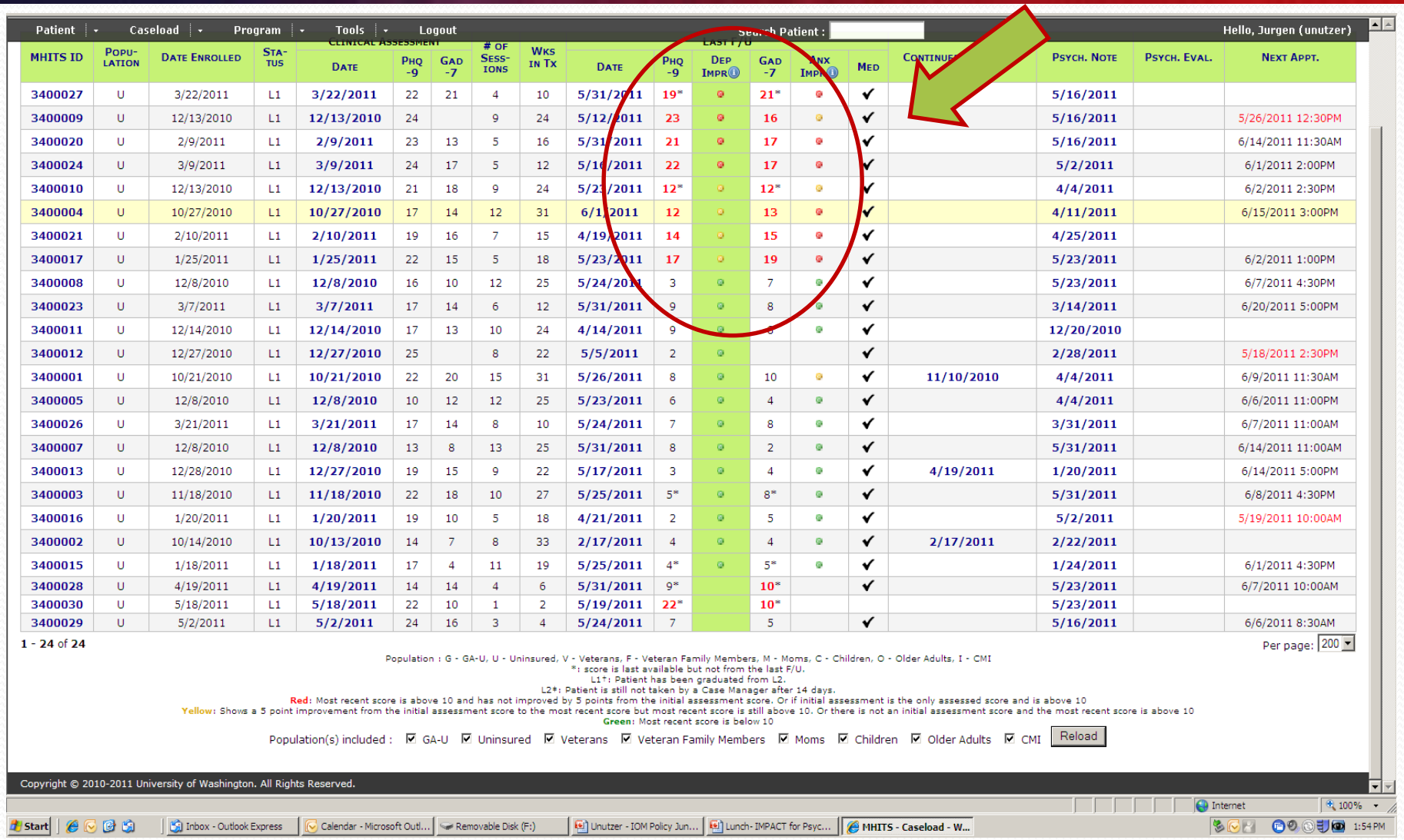
Who are the BHPs/CM?

- Typically MSW, LCSW, MA, RN, PhD, PsyD
- Variable clinical experience

What makes a good BHP/CM?

- Organization, self confident, interruptible, creative, flexible, "thick-skinned," willing to work in team, no "fern and lamp"
- **BHP Toolkit: Evidence-Based Brief Interventions**
  - **Motivational Interviewing**
  - **Problem Solving Therapy/Solution Focused Brief Therapy**
  - **Distress Tolerance Skills**
  - **Behavioral Activation**

Systematic Caseload Review of a Registry



Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment Date	PHQ -9	GAD -7	# of Sess-ions	Wks in Tx	Last F/U Date	PHQ -9	Dep Impr	GAD -7	Anx Impr	Med	Continue	Psych. Note	Psych. Eval.	Next Appt.
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓		5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/12/2011	23		16		✓		5/16/2011		5/26/2011 12:30PM
3400020	U	2/9/2011	L1	2/9/2011	23	13	5	16	5/31/2011	21		17		✓		5/16/2011		6/14/2011 11:30AM
3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/10/2011	22		17		✓		5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓		4/4/2011		6/2/2011 2:30PM
3400004	U	10/27/2010	L1	10/27/2010	17	14	12	31	6/1/2011	12		13		✓		4/11/2011		6/15/2011 3:00PM
3400021	U	2/10/2011	L1	2/10/2011	19	16	7	15	4/19/2011	14		15		✓		4/25/2011		
3400017	U	1/25/2011	L1	1/25/2011	22	15	5	18	5/23/2011	17		19		✓		5/23/2011		6/2/2011 1:00PM
3400008	U	12/8/2010	L1	12/8/2010	16	10	12	25	5/24/2011	3		7		✓		5/23/2011		6/7/2011 4:30PM
3400023	U	3/7/2011	L1	3/7/2011	17	14	6	12	5/31/2011	9		8		✓		3/14/2011		6/20/2011 5:00PM
3400011	U	12/14/2010	L1	12/14/2010	17	13	10	24	4/14/2011	9		8		✓		12/20/2010		
3400012	U	12/27/2010	L1	12/27/2010	25		8	22	5/5/2011	2				✓		2/28/2011		5/18/2011 2:30PM
3400001	U	10/21/2010	L1	10/21/2010	22	20	15	31	5/26/2011	8		10		✓	11/10/2010	4/4/2011		6/9/2011 11:30AM
3400005	U	12/8/2010	L1	12/8/2010	10	12	12	25	5/23/2011	6		4		✓		4/4/2011		6/6/2011 11:00PM
3400026	U	3/21/2011	L1	3/21/2011	17	14	8	10	5/24/2011	7		8		✓		3/31/2011		6/7/2011 11:00AM
3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓		5/31/2011		6/14/2011 11:00AM
3400013	U	12/28/2010	L1	12/27/2010	19	15	9	22	5/17/2011	3		4		✓	4/19/2011	1/20/2011		6/14/2011 5:00PM
3400003	U	11/18/2010	L1	11/18/2010	22	18	10	27	5/25/2011	5*		8*		✓		5/31/2011		6/8/2011 4:30PM
3400016	U	1/20/2011	L1	1/20/2011	19	10	5	18	4/21/2011	2		5		✓		5/2/2011		5/19/2011 10:00AM
3400002	U	10/14/2010	L1	10/13/2010	14	7	8	33	2/17/2011	4		4		✓	2/17/2011	2/22/2011		
3400015	U	1/18/2011	L1	1/18/2011	17	4	11	19	5/25/2011	4*		5*		✓		1/24/2011		6/1/2011 4:30PM
3400028	U	4/19/2011	L1	4/19/2011	14	14	4	6	5/31/2011	9*		10*		✓		5/23/2011		6/7/2011 10:00AM
3400030	U	5/18/2011	L1	5/18/2011	22	10	1	2	5/19/2011	22*		10*				5/23/2011		
3400029	U	5/2/2011	L1	5/2/2011	24	16	3	4	5/24/2011	7		5		✓		5/16/2011		6/6/2011 8:30AM

1 - 24 of 24

Per page: 200

Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1↑: Patient has been graduated from L2.
L2≠: Patient is still not taken by a Case Manager after 14 days.
Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10
Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... | 1:54 PM

If Patients Do Not Improve, Consider…

- Wrong diagnosis?
- Problems with treatment adherence?
- Insufficient dose/duration of treatment?
- Side effects?
- Other complicating factors?
  - Psychosocial stressors/barriers
  - Medical problems/medications
  - "Psychological" barriers
  - Substance abuse
  - Other psychiatric problems
- Initial treatment not effective?

Example Consultations: ~12 in 30 Minutes

Reason for Consult	Diagnosis	Recommendation
Med SE from lithium	BP 1	Switch to valproic acid
SE from lisdexamfetamine	ADHD	Try another per protocol
Lithium level is 1.2	BP 1	Continue unless having SE
Increased depression symptoms	MDNOS	TSH, if normal, start lamotrigine
Poss SE from quetiapine fumarate	BP 1/PD	Decrease quetiapine fumarate 100 mg
Paroxetine not effective	MDD	Add bupropion
Regular lamotrigine or XR?	BP 2	No difference
SE from citalopram	MDD	Switch to bupropion
Depression symptoms increased	BP1	Check lithium level
Suicidal, acute distress	PD	Safety plan, therapy
High doses of medications, confused	MDD	Stop hydroxyzine, reduce lorazepam, call collateral
Anxious, wants alprazolam, nipple pain	GAD	No alprazolam, increase sertraline, coping skills

BP = bipolar; ADHD = attention deficit/hyperactivity disorder; MDNOS = mood disorder not otherwise specified; MDD = major depressive disorder; TSH = thyroid stimulating hormone; PD = Parkinson's disease; GAD = generalized anxiety disorder.

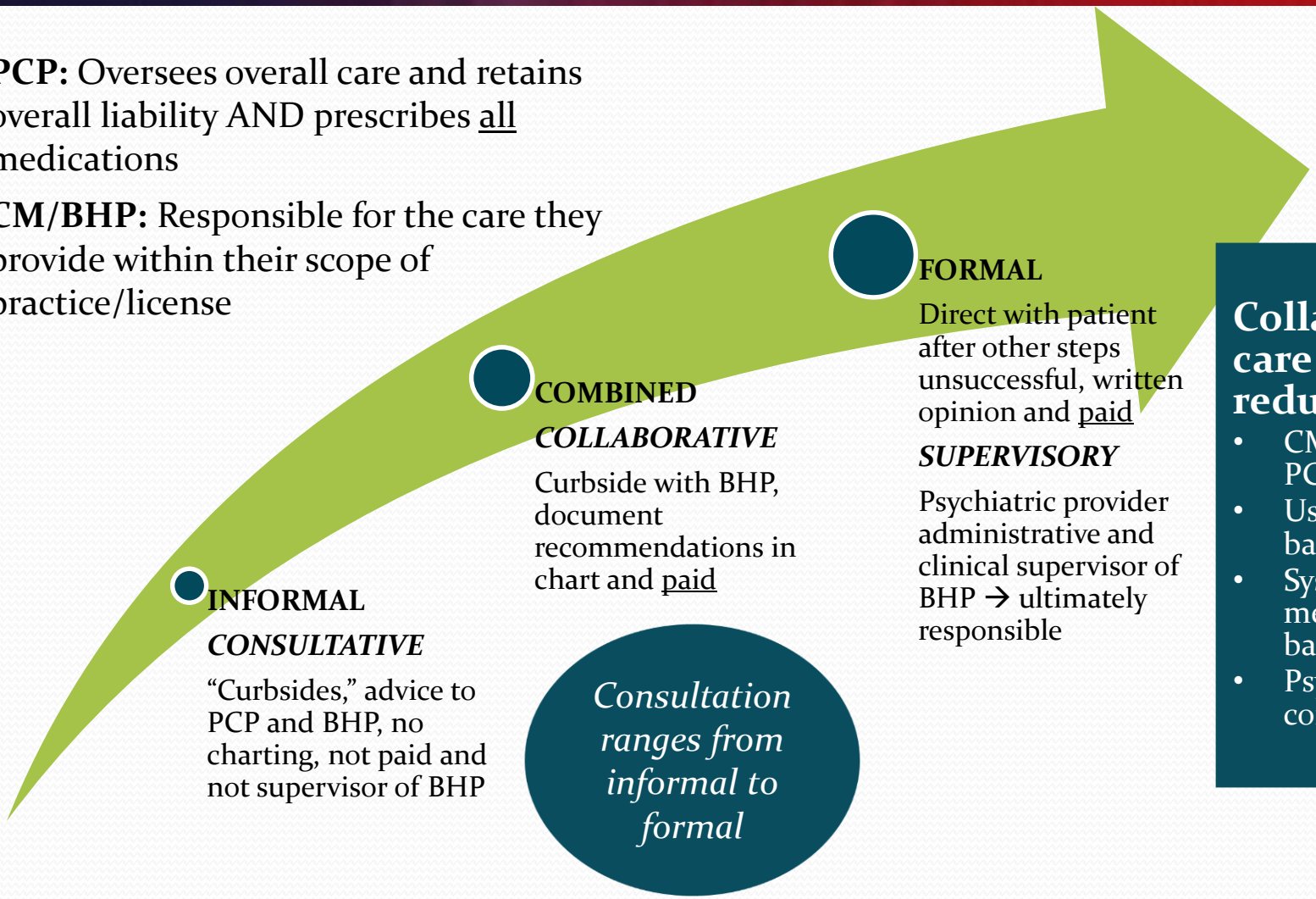
Scope of Practice

- What is the environment in which you are consulting and are you comfortable providing support for all these populations?
  - Adults
  - Children
  - Pregnant patients
  - Older adults
  - Chronic pain
  - Substance use treatment

Liability Issues

PCP: Oversees overall care and retains overall liability AND prescribes all medications

CM/BHP: Responsible for the care they provide within their scope of practice/license



Collaborative care should reduce risk:

- CM supports the PCP
- Use of evidence-based tools
- Systematic, measurement-based follow-up
- Psychiatric consultant

APA Resource Document 2014. www.psych.org. Accessed July 19, 2014.

Psychiatrists Best Suited for this Work

- Flexible: expect the unexpected
- Adaptable: child and other populations
- Willing to tolerate interruptions
- Able to manage liability concerns
- Like teaching
- Enjoy being part of a team
- Willing to lead
- **Extending psychiatric expertise to a larger population

Blessed are the flexible for they shall not get bent out of shape

Payment for Collaborative Care

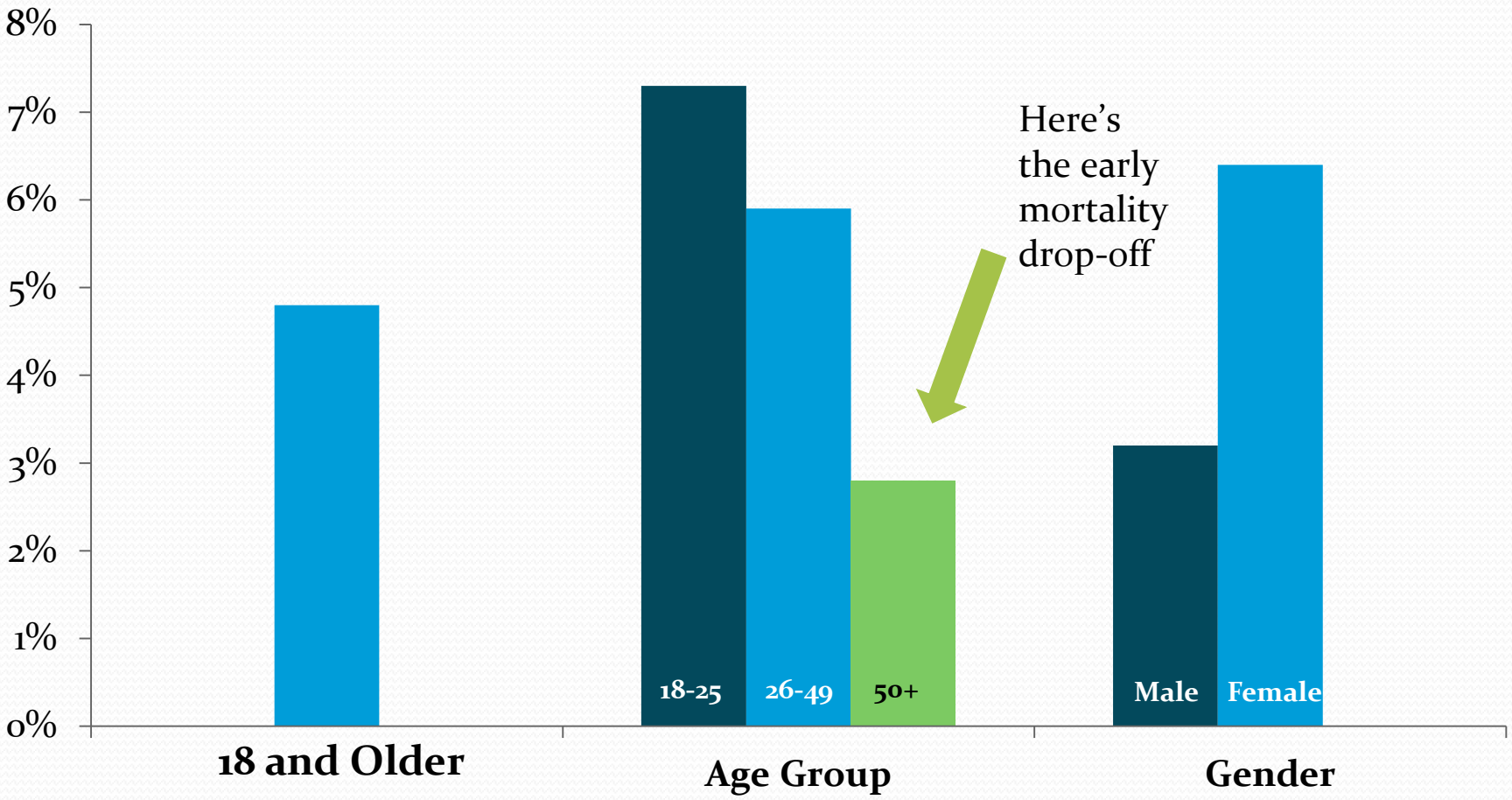
- **Fully capitated**
  - Kaiser Permanente
  - VA, DOD, IHS
- **CMMI – Innovation Grant Projects**
- **Partially capitated: PCP bills FFS; clinics get payment for care management resources**
  - Washington State Mental Health Integration Program
  - P4P Incentive
- **Case rate payment: for care management and psychiatric consultation**
  - DIAMOND Program

VA = Veterans Admiration; DOD = Department of Defense; IHS = Indian Health Service; CMMI = Center for Medicare & Medicaid Innovation; FFS = fee for service; P4P = pay for performance.

Primary Care for SMI

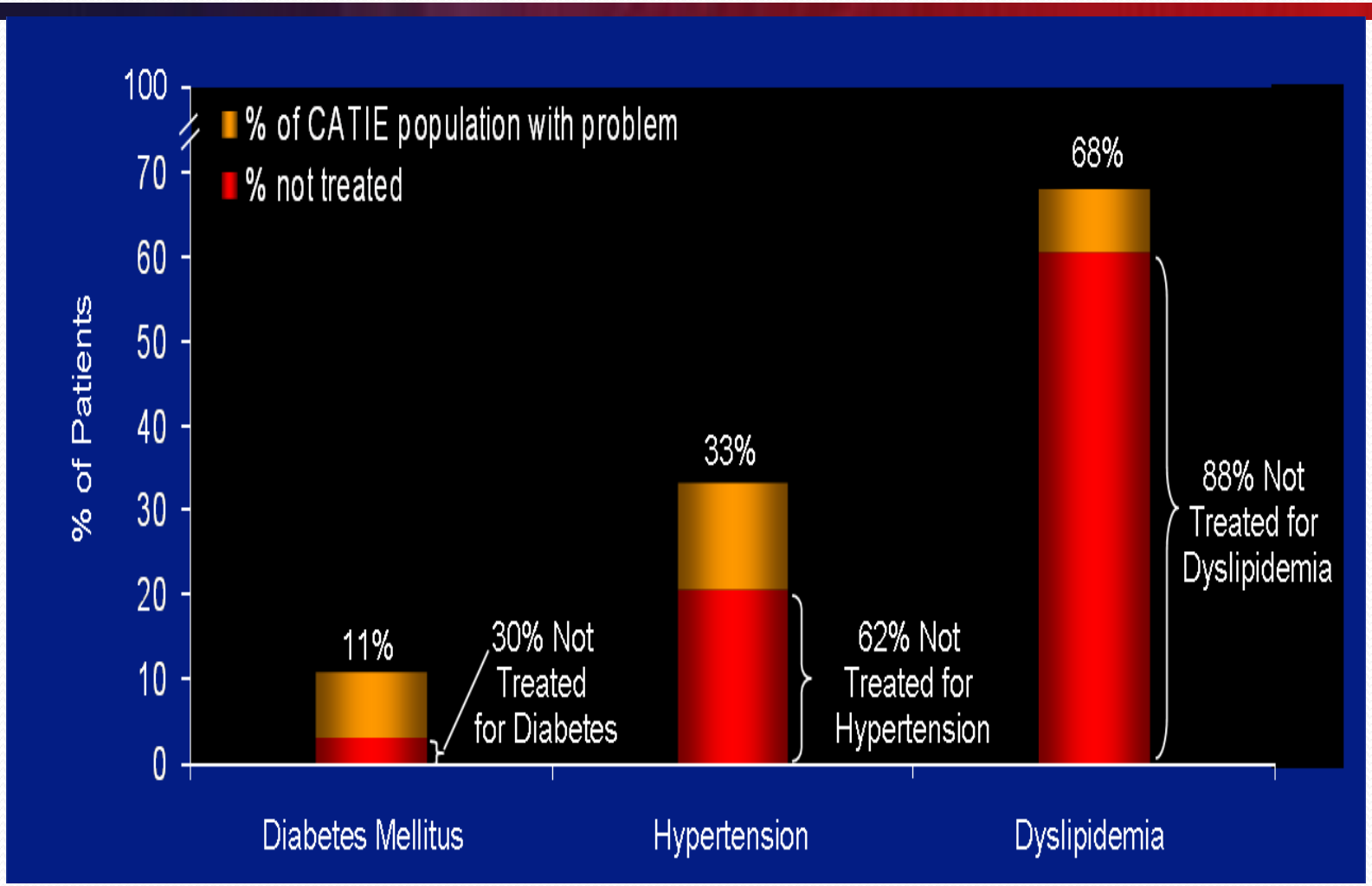
- High rates of physical illness in mentally ill
- Premature mortality
- Low quality of medical care to patients with mental illness
- *Costly physically ill with mental illness – "High Utilizers"*
- Access problems

Serious Mental Illness in the Past Year Among Adults



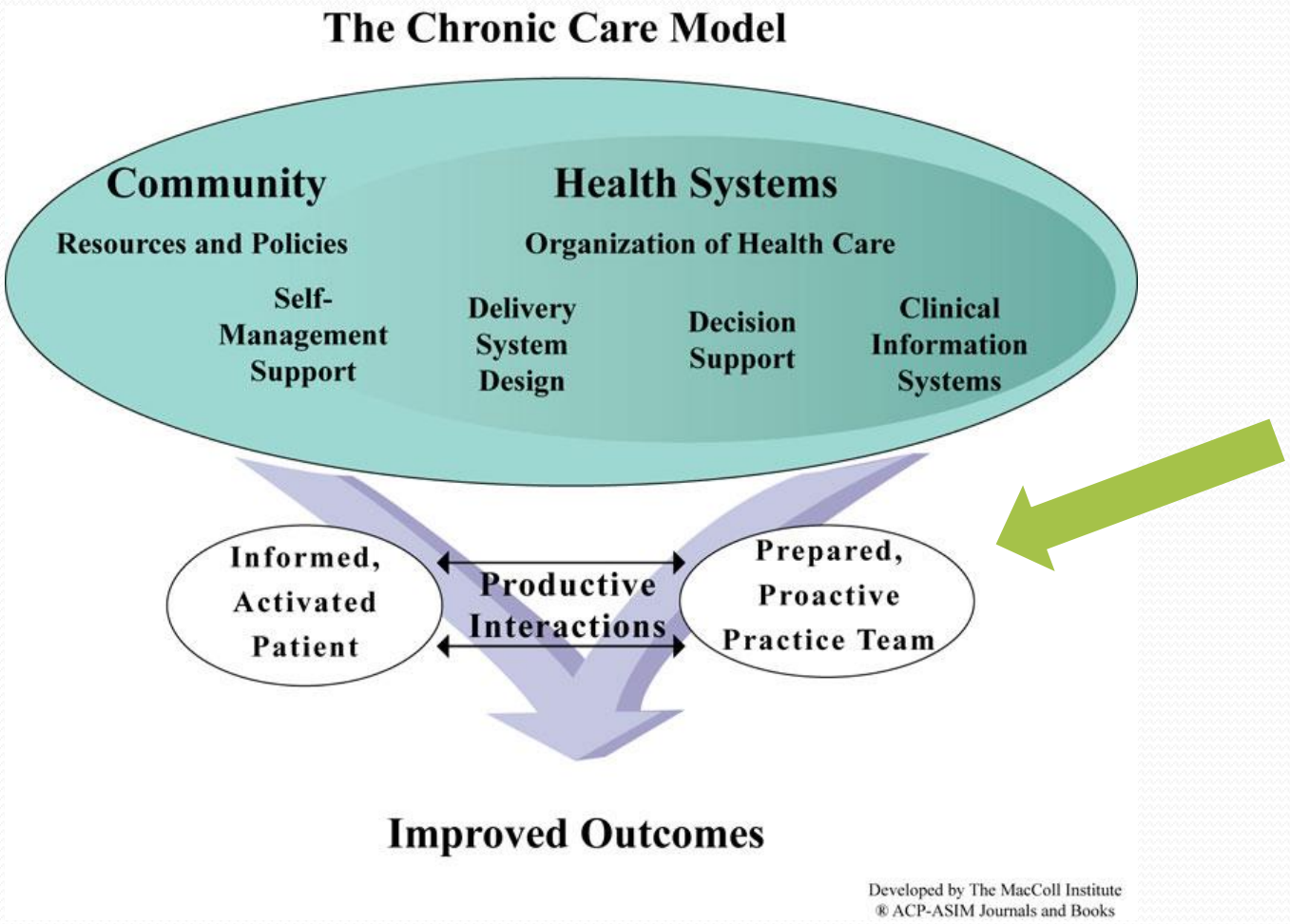
Data courtesy of SAMHSA.

Rates of Nontreatment



Nasrallah HA, Meyer JM, Goff DC, McEvov JP, Davis SM, Stroup TS, Lieberman JA: Low rates of treatment for hypertension, dyslipideamia and diabetes in schizophrenia: data from the CATIE schizophrenia trial sample at baseline. Schizophrenia Research 2006. 86(1-3):15-22

Wagner Chronic Care Model: 1990s



The Chronic Care Model. www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2. Accessed July 19, 2014.

Programs Generally Contain 3 Major Components:

Primary Care Service

Care Management and Tracking

Health Behavior Change

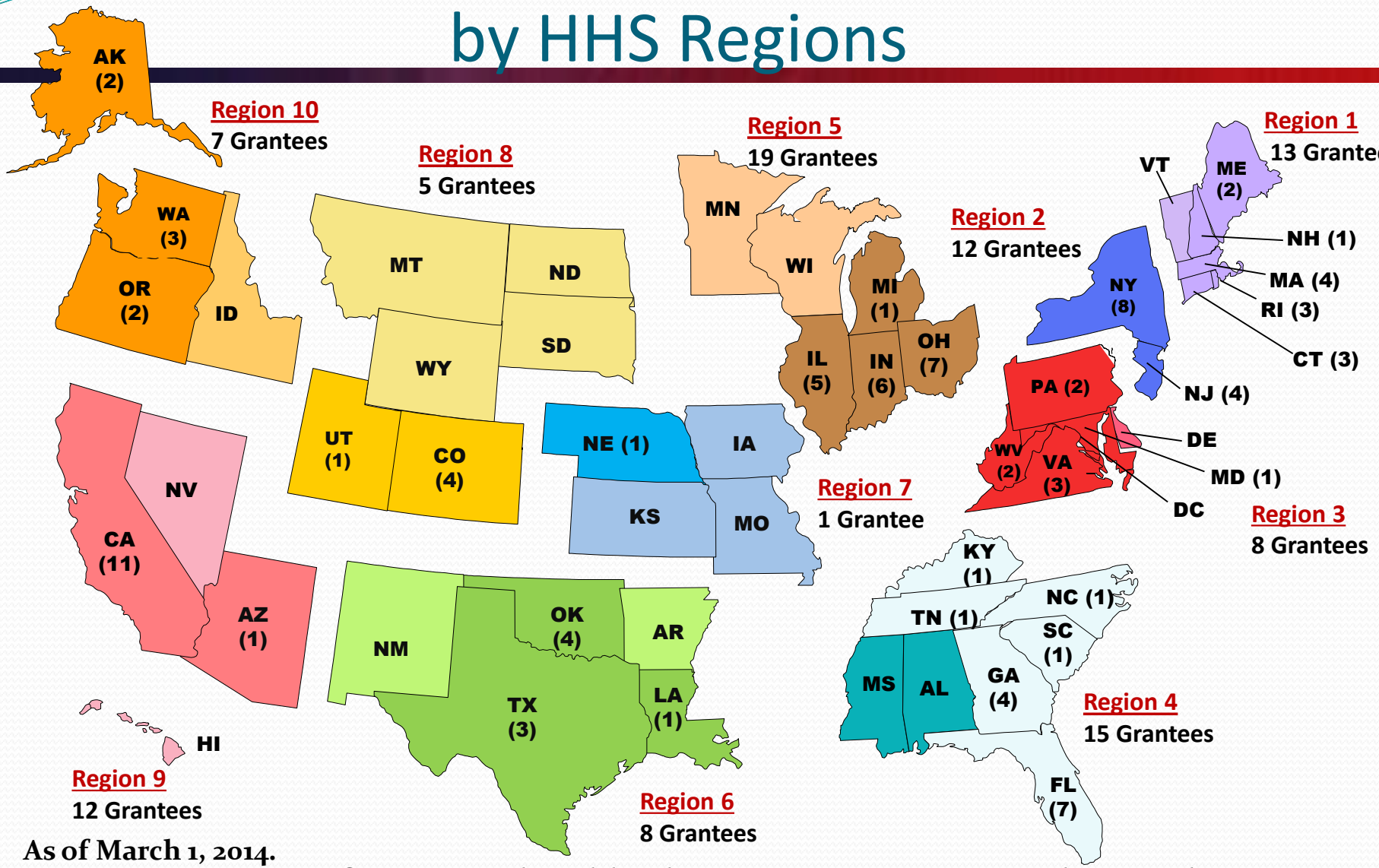
Kern J in Integrated Care: Working at the Interface of Primary Care and Behavioral Health, L Raney editor, publication September 2014

PCARE

- PCARE study: *Nurse Care Managers* provided communication and advocacy to overcome barriers to primary medical care
- Intervention group received more
  - Recommended preventive services
  - Higher proportion of evidence-based services for cardiometabolic conditions
  - More likely to have a PCP (71.2% vs 51.9%)
- *Reduction in Framingham Cardiovascular Risk Index score in intervention group: 6.9% compared with usual care 9.8%*

PCARE = Primary Care Access, Referral, and Evaluation.
Druss BG, et al. *Am J Psychiatry*. 2010;167(2):151-159.

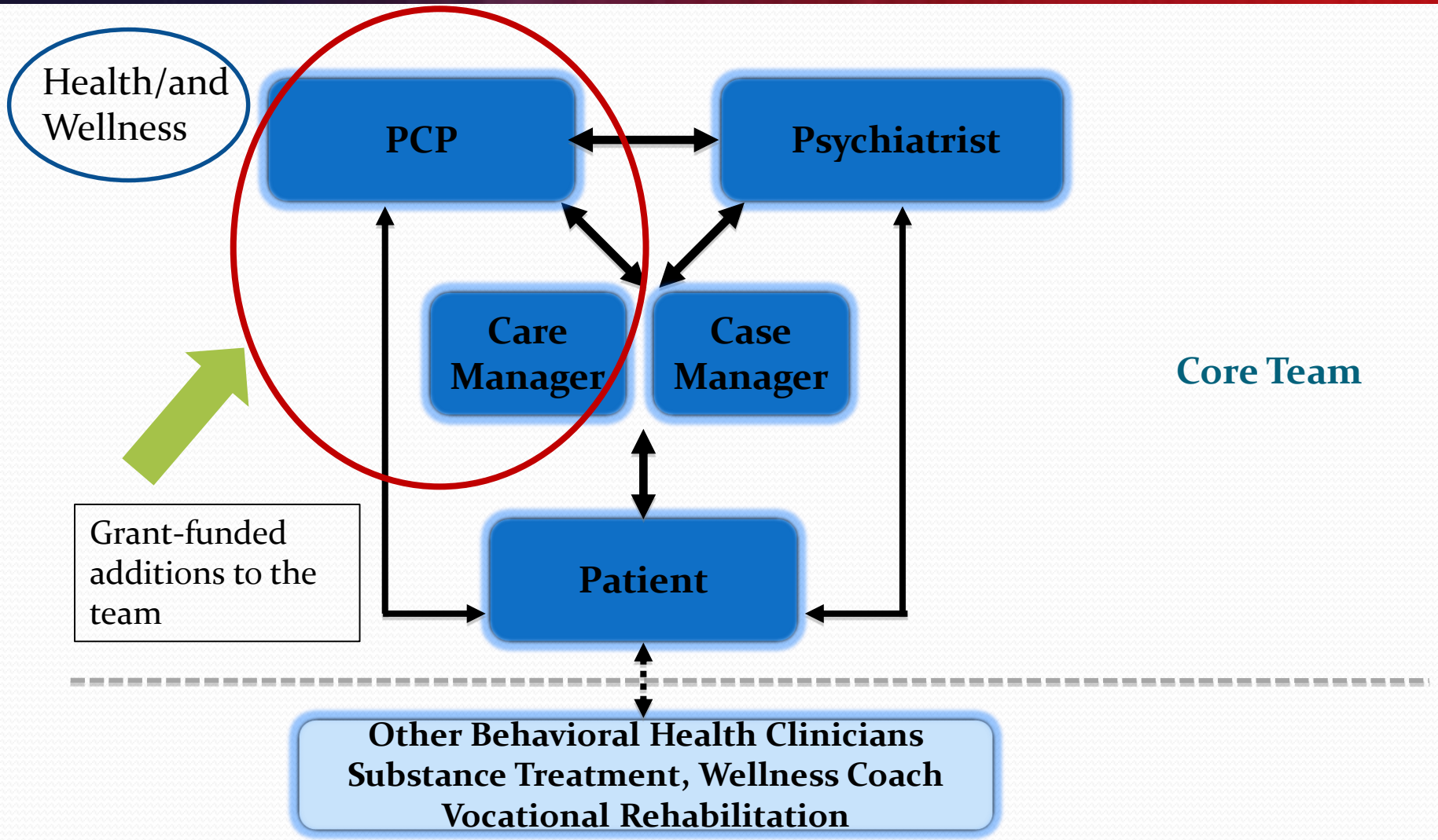
Primary Behavioral Health Care (PBHCI) Grantees by HHS Regions



As of March 1, 2014.

SAMHSA-HRSA. Center for Integrated Health Solutions. www.integration.samhsa.gov/about-us/PBHCI_Grantees_-Cohort_I-VI-.pdf. Accessed July 19, 2014.

PBHCI Approach



PBHCI RAND Evaluation #1

- Registries not simple to construct; data gathering difficult
- Recruiting and retaining qualified staff; PCP turnover
- Patient recruitment; lack of perceived need for care
- Space and licenses to do primary care

Sharf DM, et al. *Psychiatric Services.* 2013;64(7):660-665.

PCPs Qualities

- Flexible
- Adapts well to behavioral health environment
- Likes working with patients with mental illnesses – compassion and passion
- Enjoys being part of a team: no lone rangers
- Want to make a difference in a health disparity group

- ***PCP curriculum will soon be available***

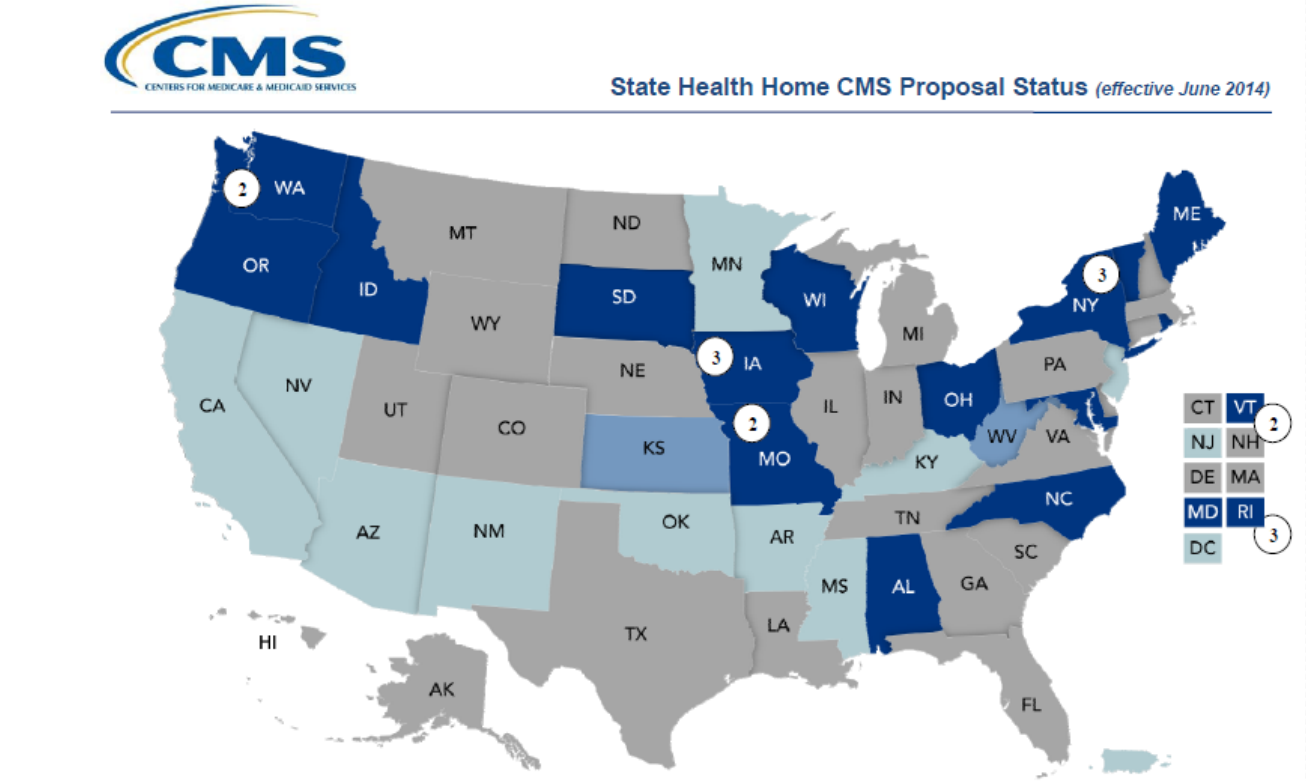
http://www.integration.samhsa.gov – **Pending HRSA approval**

PBHCI RAND Evaluation #2

- Integrated systems of various kinds created
- Limited use of Evidence Based Practices for smoking, obesity
- Not able to identify centers which functioned best
- Small clinical evaluation did not show significant effect on physical health

Scharf, et al. 2013 Report to HHS. http://aspe.hhs.gov/daltcp/reports/2013/PBHCIfr.shtml
EBP = Evidence based practice

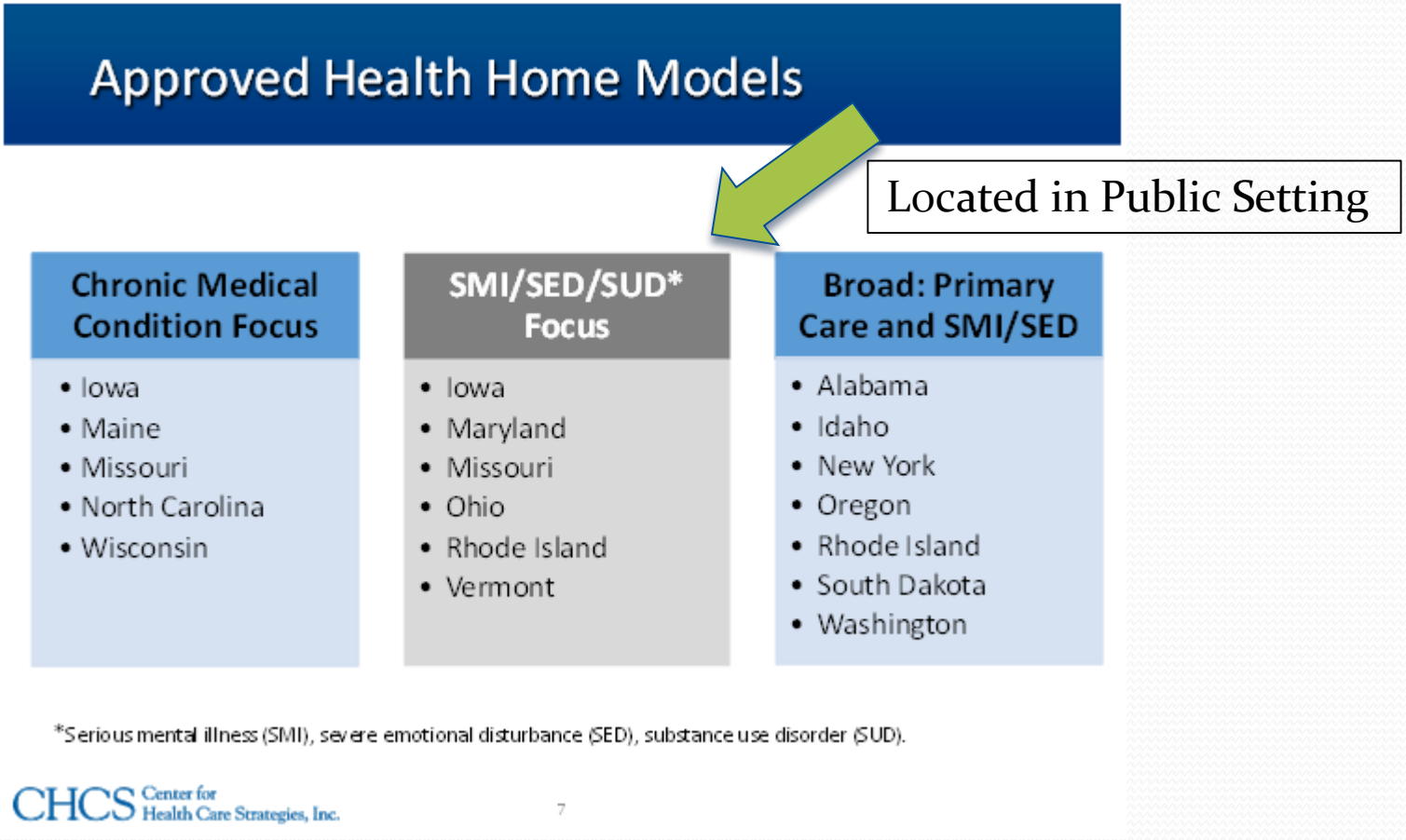
2703 Medicaid State Plan Amendments



	Approved Health Home State Plan Amendment (SPA) (where # = number of approved SPAs if more than one exists)	Alabama, Idaho, Iowa, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, Wisconsin
	Health Home SPA "On the Clock" (officially submitted to CMS)	Iowa, Kansas, Maine (response to Request for Additional Information (RAI) pending for 2nd SPA), Ohio (RAI pending for 2nd SPA), West Virginia, Wisconsin (RAI pending for 2nd SPA)
	Approved Health Home Planning Request	Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Puerto Rico, Washington, West Virginia, Wisconsin
	No Proposed SPA Submitted to CMS*	Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Wyoming

www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v34.pdf. Accessed July 19, 2014.

Health Home Focus



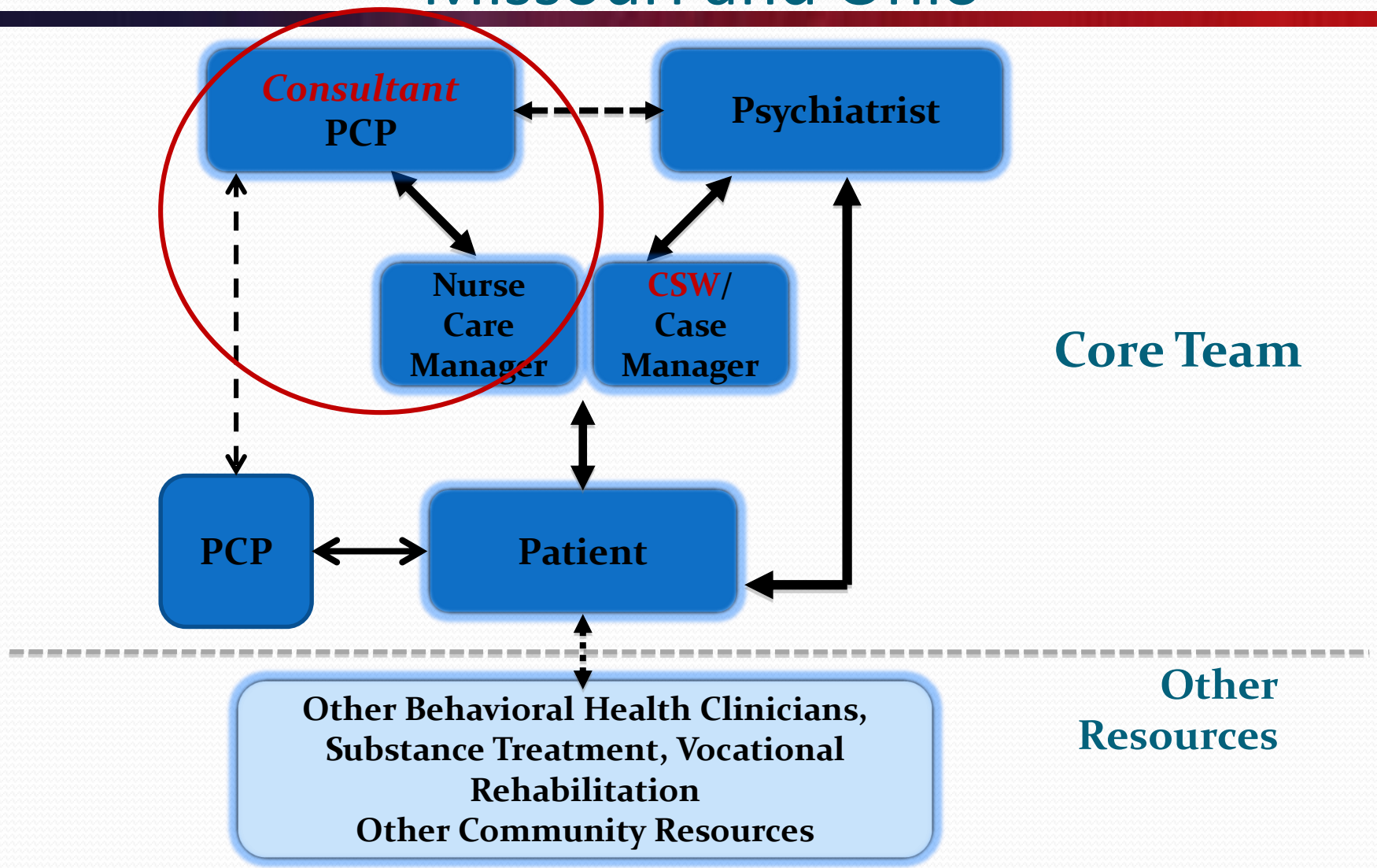
www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v34.pdf. Accessed July 19, 2014.

6 Required Services (No Direct Primary Care)

- Individual and Family Support
- Comprehensive Care Management
- Care Coordination
- Referral to Community and Social Support Services
- Health Promotion
- Comprehensive Transitional Care

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html

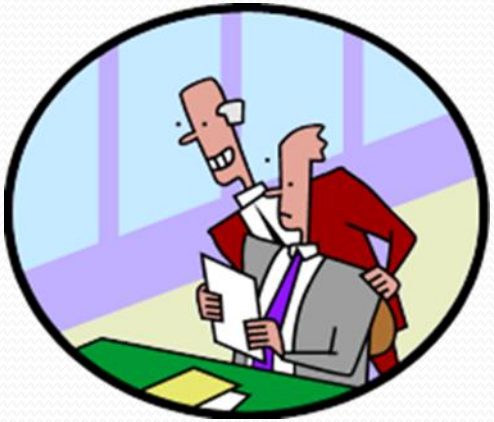
Health Home Approach: Missouri and Ohio



CSW = clinical support worker.

Consultant PCP Duties

- Case consultation
- Collaboration
- Population management
- Education

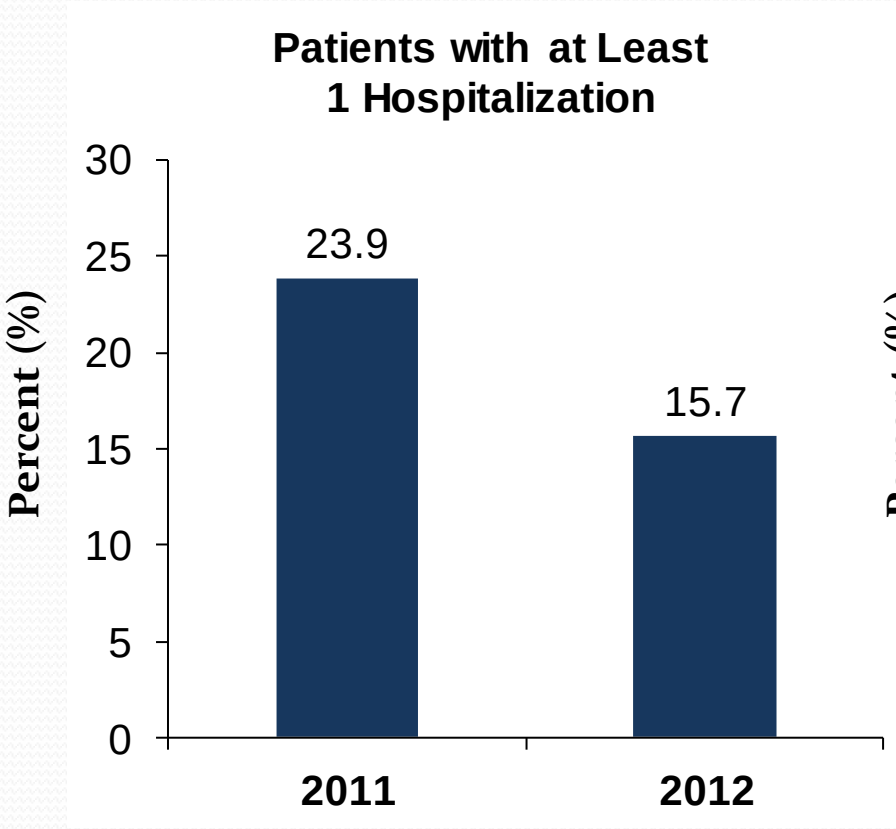


- *Does this look familiar?*

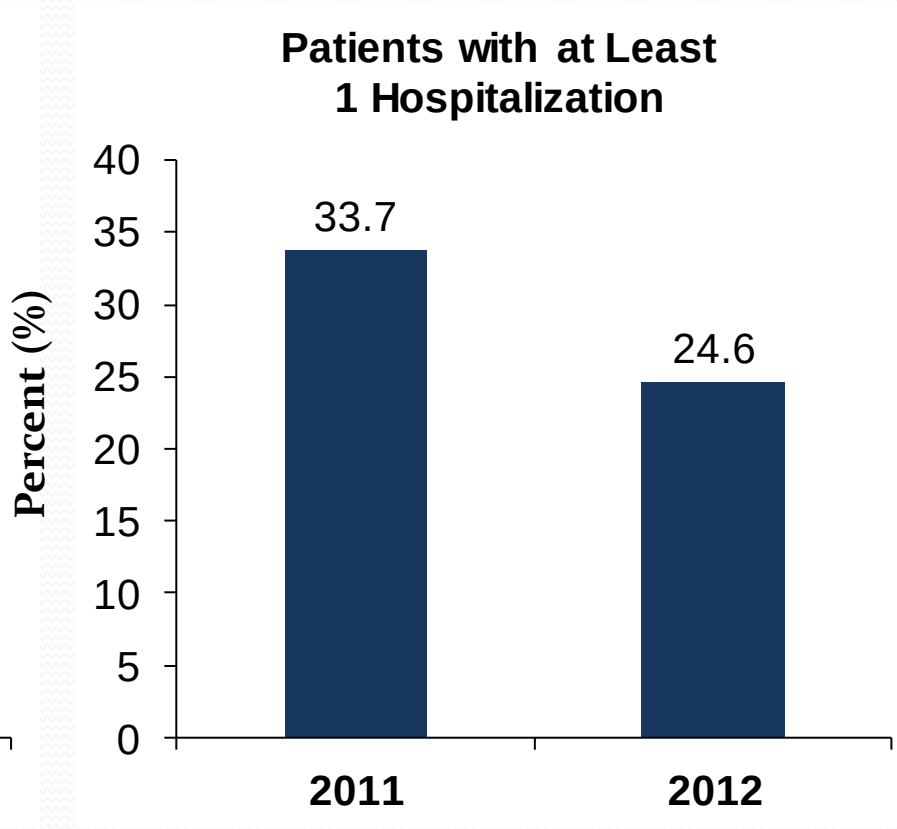
- *Looking over your shoulder to make sure adequate care is being provided*

Outcomes Reducing Hospitalization

Primary Care Health Homes



CMHC Healthcare Homes



dmh.mo.gov/docs/mentalillness/18MonthReport.pdf

Health Outcomes Management and Evaluation (HOME) Study

- 300 patients with SMI and at least 1 chronic condition: diabetes, HTN, dyslipidemia, heart disease
- Randomized to usual care or intervention
- Partner with FQHC on site
- "Integrated Care Community" (ICC) will provide care for both the index cardiometabolic conditions and common acute and chronic comorbidities
- Medical outcomes and budget analysis

HTN = hypertension; FQHC = federally qualified health center
Druss, NIMH funded. http://clinicaltrials.gov/ct2/show/NCT01228032

Roles for Psychiatrists

Co-Management

- Each provider has their own caseload
- PCP manages all medical problems
- Psychiatrist manages all mental health problems
- Work together to re-enforce treatment plans
- Psychiatrist screens for medical problems
- Same site or different
- Facilitated referral

Manage with Primary Care Consultation

- Psychiatrist works with a nurse care manager
- Manages a caseload of patients for BOTH mental health and basic medical problems
- Utilize protocols from PCP
- PCP available for consultation and stepped care as needed
- Outside PCP care continued

Comprehensive Management

- Typically dually trained psychiatrist
- One provider manages both medical and mental health problems
- Limited number of providers have this expertise

All psychiatrists are responsible for "not making people sicker"

What Is the Psychiatrist's Role in Improving Heath Status?

- **Minimizing** metabolic effects of psychotropic medications – study showing agents with higher cardiometabolic risk were prescribed to over 75% of individuals with cardiometabolic disorders
- **Screening** for cardiometabolic risk factors – APA/ADA Guidelines
- **Counseling** for lifestyle issues - tobacco, obesity, diet
- **Treating** some basic medical conditions
- **Leading** teams – psychiatrists uniquely trained

Adapted from Ben Druss, MD, MPH, 2010.
SGAs = second-generation antipsychotics.
Hermes ED, et al. *Psychiatric Services.* 2013;64(3):238-244. Clark NG, et al. *Diabetes Care.* 2004;27(2):596-601.
Nonfasting Screening for cardiovascular risk among individuals taking second generation antipsychotics, Vanderlip et al. Psychiatric Services 65:573–576, 2014

Psychiatrists Treating Common Medical Conditions

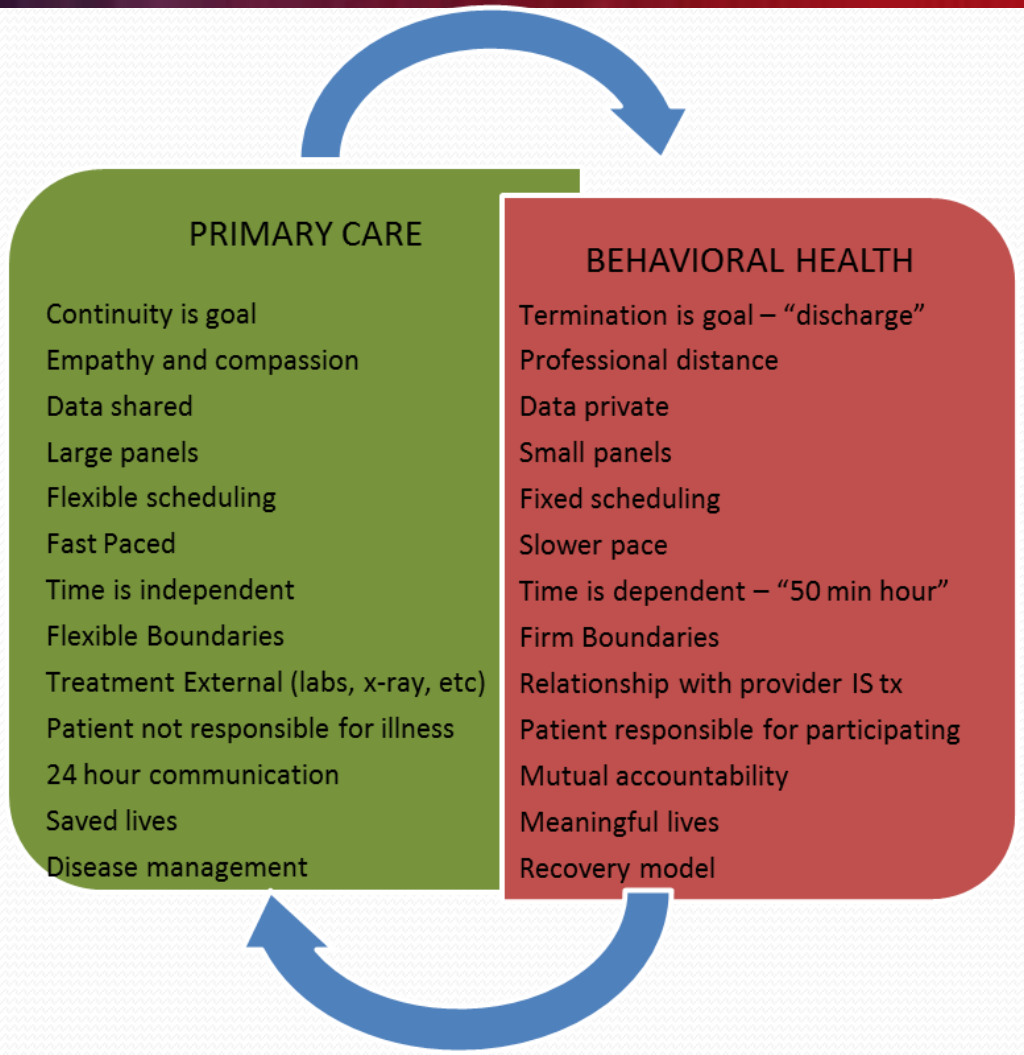
- Joint APA/AMP Position Statement – in progress
- Courses at APA meetings
- PCP collaboration
- Prevention in Psychiatry – McCarron et al, American Psychiatric Publishing, Fall 2014

Hypertension Dosing Guideline

1st LINE: Thiazide, Diuretics **Unless have CHF, diabetes, CKD**	• HCTZ 12. 5 mg, 25 mg, 50 mg (max) • Chlorthalidone 25 mg (max)	• QD dosing • Check electrolytes 4-6 weeks, then every 3 months, then annually • Add second agent if partial response • National Generic $ 4 list – both
2nd LINE: ACE Inhibitors **1st line for above diagnosis**	• Lisinopril 5mg, 10 mg • Enalapril 2.5mg, 5 mg, 10 mg, 20 mg	• Start at 5-10 mg/day and titrate up to as much 40 mg /day • Check electrolytes 8-10 weeks; stop if CR >2.5 • Dry cough, elevated CR, angiodema, facial swelling, do not use in pregnancy • $ 4 list
3rd LINE: CCBs	• Amlopidine 2.5 mg, 5 mg, 10 mg (max) • Nifedipine LA 30 mg, 60 mg (max 90 mg)	• Very potent, if adding as third agent call PCP first! • Can cause peripheral edema
4th LINE: Beta Blockers	• Metoprolol succinate (XL) 25, 50, 100, 200 (200 mg max)	• QD • Do not give if pulse <55, 25-100 mg/day usual • Can go to max 200 mg
Remember, BP 139/89 mm hg is fine for all patients	***Adjust meds every 2 weeks, follow up every 3-6 months once stable***	***If K+ falls below nl and BP responding, add 10 meq K+ up to total dose 20 mg***

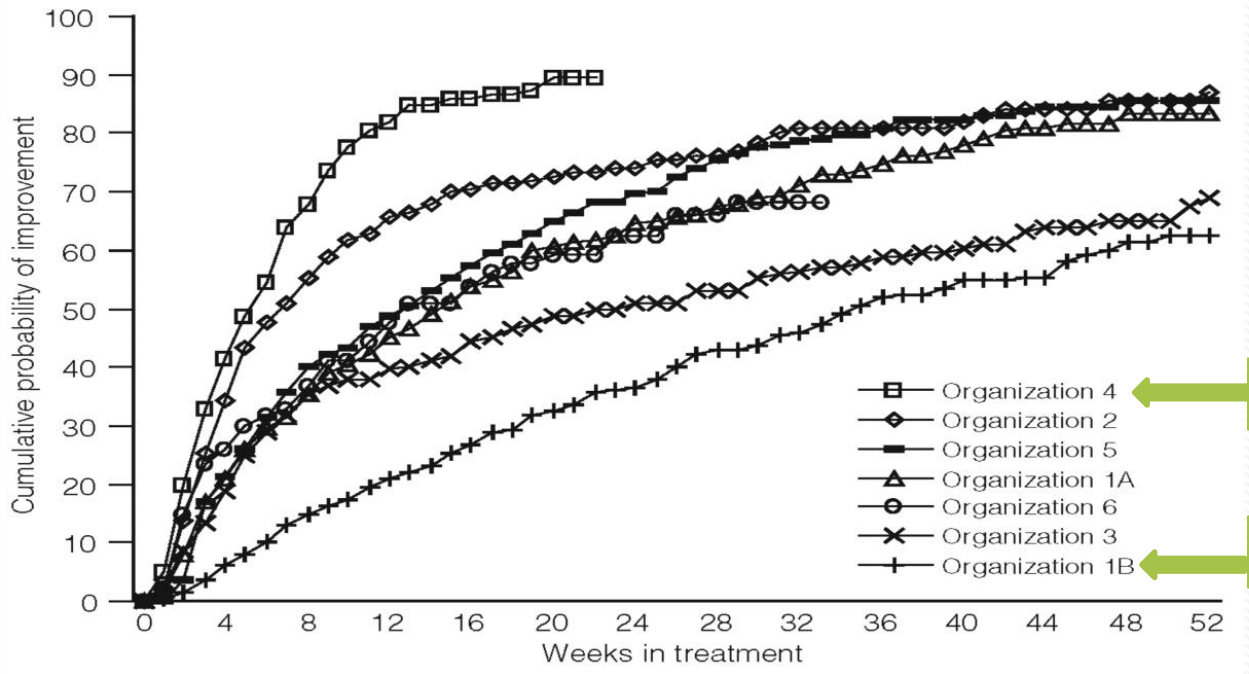
CHF = congestive heart failure; CKD = chronic kidney disease; ACE = angiotensin-converting-enzyme; CCB = calcium channel blocker; HCTZ = hydrochlorothiazide; CR = creatinine.

2 Cultures, 1 Patient



Estimated Time Between Initial Assessment and Improvement

Estimated Time Elapsed between Initial Assessment and Improvement of Depression During First Year of Treatment: 6 Organizations



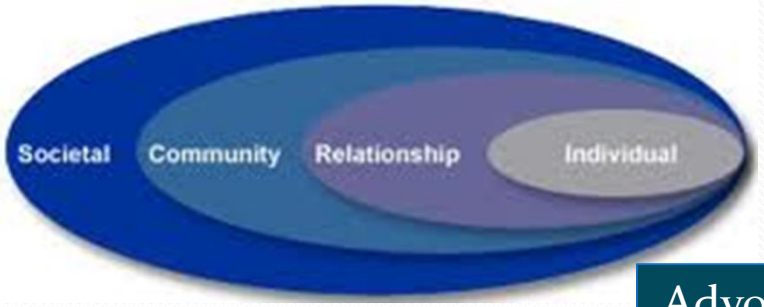
Bauer AM, et al. *Psychiatric Services.* 2011;62(9):1047-1053.

Roles for Psychiatrists

Specialist

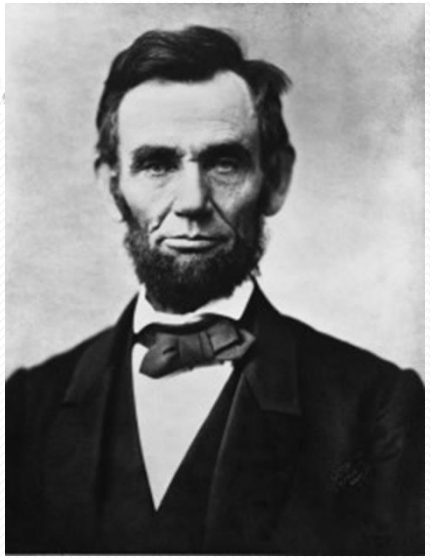
Public Health Practitioner

Behaviorist



Advocate

Internist



Leader

Practical Tips

- Know different models of integration so you can adapt them to suit your environment
- Use the Core Principles of Effective Collaborative Care as a compass to guide your program design and implementation
- Make sure you understand the role of the psychiatrist in these varying models. The shifts in traditional roles may be uncomfortable and strong leadership is necessary to make this transition.

Take the Leap!

The Evolving Role of Psychiatry in the Era of Health Care Reform

Lori Raney, M.D.

Health care reform offers psychiatrists, who are trained in both general medical and behavioral health care, many opportunities to assume leadership roles on collaborative care teams and improve patient outcomes. This column describes such opportunities in primary care and public mental health settings and outlines new competencies, such as enhanced primary care skills, that will allow psychiatrists to expand their scope of practice in new models of care in the era of reform. These changes will require training, and the author calls on leaders of the American Psychiatric Association to help psychiatrists obtain new skills and undertake new roles. (*Psychiatric Services* 64:1076–1078, 2013; doi: 10.1176/appi.ps.201300311)

It's an optimistic time to be a psychiatrist in this country. As health care reform progresses to full realization in 2014 and the health care field turns its collective compass in the direction of the "triple aim," psychiatrists will have opportunities to collaborate with their medical colleagues to improve outcomes and cost efficiencies while enhancing patients' experience of care. Such collaborations have the potential to move the field of psychiatry to a new level of relevance. The psychiatrist of tomorrow will need to prepare for these changes by developing a broader set of competencies and accepting a culture of shared accountability.

Coupled with these changes is a chance to provide expert guidance and leadership if psychiatrists embrace these opportunities and adequately position themselves at the forefront of this movement. Failure to do so at this important juncture places psychiatrists in a precarious position with their medical colleagues, who have a gap to fill to effectively treat mental illnesses. Psychiatrists have a foundational skill set that is distinct from those of other behavioral health disciplines. Their training in both the general medical and the behavioral health worlds makes them well situated to lead this effort. This column outlines the opportunities available—and the competencies necessary—to shift the role of psychiatry to accommodate the needs of the larger medical community in health care reform.

Areas of opportunity

Several emerging areas will benefit from the expertise of psychiatrists and their enhanced presence, particularly in the area of primary care. The potential for a mutually beneficial relationship between psychiatry and primary care exists, given the need in primary care settings for improving outcomes of treatments for mental illnesses and the need in public mental health settings for treating the medical conditions of the most vulnerable patients. In addition, it is clear that untreated mental illness accounts for substantial increases in overall health care costs (1) and drives the use of resources in the population of patients commonly referred to as "high utilizers." Although psychiatric service lines are rarely seen as revenue generators for a health care operation, new systems that are held accountable for outcomes and cost containment will readily see the value of utilizing psychiatric expertise to contain costs while improving outcomes.

In primary care settings, it is essential for psychiatrists to become accessible and reliable consultants and to provide support to primary care providers. This may seem challenging given the shortage of psychiatrists, but it can be accomplished by collaborative care teams that are guided by the fundamental principles of the chronic care model (2), in which prepared and proactive teams provide optimal treatment. In the IMPACT approach (Improving Mood–Promoting Access to Collaborative Treatment) (3), an adaptation of the chronic care model, a consultant psychiatrist is available to the team for caseload review, "curbside" consultation, and education—and, less frequently, for direct evaluations. Working behind the scenes, the psychiatrist provides continuous input to the team in the primary care clinic, allowing extension of psychiatrists' expertise to a larger population of patients than is possible in one-to-one evaluations. Patients who are not responding to treatment at one level can be "stepped" to higher levels of care via this consultation model, and care can be quickly adjusted to ensure maximum treatment response. Primary care physicians can be encouraged to go beyond first- and second-line treatments, knowing that they are not alone and that psychiatric expertise is readily available. To be successful in this model, psychiatrists must embrace this team-based culture and the approaches used, manage and understand liability concerns in regard to consultations for patients whom they have not directly examined, be willing to

Dr. Raney is affiliated with Axis Health System, P.O. Box 248, Dolores, CO 81323 (e-mail: dlraney@centurytel.net). Benjamin G. Druss, M.D., M.P.H., is editor of this column.

consult across the life span if necessary, and be knowledgeable about HIPAA regulations to prevent misinterpretation and the risk of providers' not knowing what is in each other's charts.

In public mental health settings, there is a growing call for psychiatrists to be responsible for and prepared to assume greater medical oversight of the general medical care of their patients, particularly individuals with serious mental illnesses. At a minimum, psychiatrists are responsible for problems caused by psychiatric medications. Given the potential cardiovascular side effects of second-generation antipsychotics and other psychiatric medications, this principle is difficult to uphold while psychiatrists are also trying to control the potentially devastating and life-threatening symptoms of serious mental illnesses. However, psychiatrists need to acknowledge that these medications have contributed to worsening health outcomes and take responsibility for addressing the consequences.

A set of principles is emerging to guide care to offset some of the risks and help patients become healthier (4). These principles include minimizing the effects of medications, such as second-generation antipsychotics, by choosing those with less potential for harm. Although this may seem like a logical and often used approach, a recent study by Hermes and colleagues (5) showed that over 75% of patients with mental illnesses who had cardiometabolic disorders were receiving medications that presented a higher cardiometabolic risk than other similar medications.

Another important principle is to regularly screen patients for underlying chronic medical conditions and any worsening of illnesses resulting from the effects of medications. This includes use of tools such as the 2004 screening guidelines developed by the American Diabetes Association and the American Psychiatric Association for patients taking second-generation antipsychotics, which call for monitoring specific health parameters. Here again, discrepancies have been noted between psychiatrists' knowledge that screening is important and should occur regularly (6) and their screening practices (7). A third principle is the vital role that psychiatrists can play in counseling their patients about lifestyle issues. From smoking cessation to exercise and diet, psychiatrists are experts in behavior change. Extending this expertise to lifestyle issues that threaten the health of patients is crucial.

A fourth and somewhat more intriguing principle is psychiatrists' treatment of some chronic general medical conditions when primary care services are not available to or utilized by patients. This will require retraining psychiatrists in general medical skills learned in medical school and residency as well as establishing a system of consultation with primary care colleagues. Finally, psychiatrists' training in the full range of medicine provides them with a unique skill set to successfully lead teams in models such as patient-centered medical homes and behavioral health homes. To be proficient leaders in these models, psychiatrists will have to develop new competencies and be willing to step forward and accept these roles. Doing so could enhance psychiatrists' relevance in public mental health settings as their overall skills in medicine become more valued on teams that must embrace whole-person care.

High utilizers of health care resources have recently been more prominently targeted for intervention, and the practice of "hot spotting" to identify them has become more widespread. Psychiatrists' roles in working with this patient cohort include being proactive in the identification and treatment of mental illnesses that can contribute to complex health conditions and the excessive use of medical services. Areas in which such intervention may be valuable include primary care clinics, emergency rooms, and community mental health centers, where some of the high utilization is linked to serious mental illnesses. Inpatient units can undertake interventions such as proactive consultation-liaison services (8) to break the cycle of poor outcomes by identifying behavioral health comorbidity.

New competencies for psychiatrists

Enhanced primary care skills will be essential for a multitude of reasons, including the need to restore psychiatrists' confidence in communicating with medical colleagues and to better prepare psychiatrists to review targeted nonpsychiatric outcomes. This knowledge will be helpful in using the new CPT coding system accurately and in addressing growing concerns about cardiovascular risk among patients with serious mental illnesses. Improving psychiatrists' knowledge about the most effective treatments for common general medical conditions could also lead to psychiatrists' providing some basic general medical care.

The move toward provision of basic treatments for common medical conditions in the psychiatrist's office has gained momentum recently for many reasons, including a lack of available primary care services and some patients' reluctance to seek care outside the mental health setting. Individuals with serious mental illnesses are substantially burdened by medical conditions. Their alarming mortality gap and their need for primary care services are well known. Psychiatrists' training in medicine will enable them to work to expand their scope of practice to once again embrace a more inclusive approach to medicine. A decade of screening and referral to primary care services has done little to move the dial on the mortality gap. Some have raised concerns that screening patients and not providing care for identified conditions may one day be more difficult to defend than attempting to provide this care by expansion of the psychiatrists' scope of practice.

Such expansion will require specific retraining, consultation, and guidance from professional organizations to be effective and accepted as an additional area of competence for psychiatrists who are willing and interested. "Consultant" and "embedded" primary care providers have been introduced in health home initiatives in Missouri and Ohio, and on-site primary care providers are employed in the Primary and Behavioral Health Care Integration grantee locations. These colleagues, whose roles in such systems mirror the roles that psychiatrists play on collaborative teams in primary care, can offer advice and guidance. Primary care providers can help raise psychiatrists' confidence in their general medical skills. One

previous study demonstrated the confidence that psychiatrists could be an appropriate treatment provider for a list of chronic conditions (9).

Practicing population-based care will be another essential competency as the focus shifts to assuming responsibility for a defined population of patients who are tracked in registries and monitored for progress and adequate follow-up. The care is more proactive than reactive, with a focus more on the denominator (all patients who need care) than on the numerator (those who request care). Utilizing population-level metrics helps establish priorities and adjust interventions to lead to better outcomes. Because of the health disparities experienced by individuals with serious mental illnesses, psychiatrists need to begin tracking specific health indicators and using knowledge obtained from these aggregate data to identify care gaps and determine a best course for intervention. Psychiatrists will need to know which illnesses to focus on, which metrics to use, and how to identify and treat patients who are high utilizers.

Using data to drive care will become even more essential as outcome measurements play a role in determining how payment is obtained for services. Utilizing a "treat-to-target" approach for both mental and general medical illnesses will be essential as predetermined goals are set and the team works to ensure that adequate treatment is provided, timely follow-up ensues, and adjustments are made if the patient is not making progress. This approach can be taken by psychiatrists to monitor treatment of depression in their practice; for example, they can make serial use of the Patient Health Questionnaire, with a goal of lowering the score to less than 5 points. Or they can follow a cohort of patients with serious mental illness and comorbid diabetes, seeking to reduce HbA1c levels to less than 7% among at least 60% of the cohort. Outcome data will be an important driver of system design and payment for services in a reformed health care system, and psychiatrists will need to acknowledge their accountability in this process.

Leadership skills will be necessary to guide teams in merging the cultures of primary care and behavioral health care, which have been siloed for decades. With one foot in behavioral health and the other in the rest of medicine, psychiatrists are in a unique position to span the gap between the two and work to reduce the resistance inherent in the process. Confidence, humility, and competence will guide this process, and successful leaders will seek to improve their knowledge and understanding of team dynamics and team-building strategies.

Conclusions

Health care reform presents many opportunities for psychiatrists to play key roles. Psychiatrists can be catalysts for change in the rapidly changing health care environment due in part to their unique training in the full spectrum of medicine, their expertise in behavior change, and their knowledge of group dynamics and team participation. This evolution will require training, and leaders of the American Psychiatric Association should heed the call, helping psychiatrists to obtain new skills and formally supporting them as they prepare to undertake new roles. For psychiatrists who are already working in new health care venues, the experience has been exciting and rewarding. We can build on this enthusiasm with medical students and residents and give the next generation of psychiatrists an opportunity to have a greater population-level impact by leveraging their skills in a different way. As a profession, now is the time to choose to "go where the ball is heading."

Acknowledgments and disclosures

The author acknowledges Wayne Katon, M.D., Jürgen Unützer, M.D., Benjamin Druss, M.D., M.P.H., and Roger Kathol, M.D., for thoughts expressed during participation on an expert panel, "The Evolving Role of Psychiatry in the Era of Healthcare Reform," at the 2013 annual meeting of the American Psychiatric Association.

The author reports no competing interests.

References

1. Melek S, Norris D, Paulus J: Economic Impact of Integrated Medical-Behavioral Health: Implications for Psychiatry. Arlington, Va, American Psychiatric Association, Feb 2013
2. Wagner EH, Austin BT, Von Korff M: Organizing care for patients with chronic illness. Milbank Quarterly 74:511–544, 1996
3. Unützer J, Katon W, Callahan CM, et al: Improving Mood-Promoting Access to Collaborative Treatment: collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA 288:2836–2845, 2002
4. Druss B: Psychiatric Leadership in Health Reform. Presented at the National Council for Behavioral Health conference, Las Vegas, April 10, 2013
5. Hermes ED, Sernyak MJ, Rosenheck RA: Prescription of second-generation antipsychotics: responding to treatment risk in real-world practice. Psychiatric Services 64: 238–244, 2013
6. Newcomer JW, Nasrallah HA, Loebel AD: The atypical antipsychotic therapy and metabolic issues national survey: practice patterns and knowledge of psychiatrists. Journal of Clinical Psychopharmacology 24 (suppl 1):S1–S6, 2004
7. Morrato EH, Druss B, Hartung DM, et al: Metabolic testing rates in 3 state Medicaid programs after FDA warnings and ADA/APA recommendations for second-generation antipsychotic drugs. Archives of General Psychiatry 67:17–24, 2010
8. Desan PH, Zimbrean PC, Weinstein AJ, et al: Proactive psychiatric consultation services reduce length of stay for admissions to an inpatient medical team. Psychosomatics 52:513–520, 2011
9. Golomb BA, Pyne JM, Wright B, et al: The role of psychiatrists in primary care of patients with severe mental illness. Psychiatric Services 51:766–773, 2000