Consultative Approaches to Leveraging the Psychiatric Workforce for Larger Populations in Need of Psychiatric Expertise

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Efforts are underway to leverage the expertise of the limited psychiatric workforce by utilizing psychiatrists as consultants to primary care providers (PCPs). These approaches have demonstrated the potential to increase access to care by having PCPs manage patients with common, less complex behavioral health conditions earlier and more effectively, thereby reducing demand for specialty psychiatric evaluation. Multiple approaches to indirect psychiatric consultation have been developed with varying levels of evidence and success. These ongoing efforts will require modifications in workforce training to prepare psychiatrists and PCPs for this new role and in reimbursement approaches that cover the cost of the psychiatric consultants' work.

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Access to psychiatric expertise is a major concern. In 2017, the workforce of 45,580 U.S. psychiatrists was considered insufficient to meet demand by a margin of 2,800 practitioners, a 6.4% shortage. This shortage is predicted to at least double by 2025. There are numerous reasons for this trend, including the number of medical students selecting psychiatry, impending retirement for over half of the psychiatric workforce, geographical maldistribution of psychiatrists, and many psychiatrists not accepting insurance due to low reimbursement rates (1). As a result, according to the Merritt Hawkins "2019 Review of Physician and Advanced Practitioner Recruiting Incentives" (2), psychiatry was the second most requested specialty to fill vacancies nationally. Given this situation, what can psychiatrists do differently to better address the demand for their services?

Consultative Approaches in Primary Care Beyond "One Patient, One Provider"

More than any other approach, the collaborative care model (CoCM) has demonstrated evidence of its ability to effectively extend the expertise of psychiatrists across larger populations than they could see in traditional outpatient care, using a consultative approach (3). In this model, psychiatric providers act as consultant team members with shared responsibility and work with a behavioral care manager who has a caseload of patients. The team's focus is on providing effective care through a treat-to-target approach in order to reach defined clinical goals (such as depression response and remission). This process often requires adjustments to care recommended by the psychiatric consultant during a weekly review of the behavioral care manager's caseload registry. The registry provides a population management approach with data from repeatedly assessing symptoms by using validated measurement tools. With this model, patients with less severe forms of psychiatric conditions or earlier presentations of serious mental health conditions receive effective treatment, are treated earlier, and experience less stigma in obtaining care. Furthermore, because psychiatrists remain in the treatment role and have enhanced communication with the primary care

HIGHLIGHTS

- Access to psychiatric expertise can be improved by utilizing a consultative approach for treating patients with common psychiatric diagnoses, accompanied by methods to increase the capacity to treat these conditions in primary care.
- Case-based learning is an important element of the consultative process and can help primary care providers attain competence and confidence in treating behavioral health conditions.
- Changes in psychiatric training and in reimbursement for consultation are necessary to further the goal of leveraging psychiatric expertise to increase access to care.

TABLE 1. Approaches to extend psychiatric reach to primary care populations[a]

Approach	Role of psychiatrist	Patient evaluation[b]	Responsibility for follow-up care	Psychiatrist available for backup	Improved access to psychiatrist by reducing referrals[c]	Benchmarks in literature for effectiveness	Covered by some insurance
Didactic presentations	Education only	None	PCP	No	Possible, if PCP practice changes	No	No
Collaborative care model	Systematic caseload review and curbside consultation; may or may not include direct evaluation of more complex presentations	Indirect for the majority of patients, direct for a few with more complex conditions or when no other access is available	PCP	Yes	Yes	Yes, for multiple conditions	Yes
Project ECHO (Extension for Community Healthcare Outcomes)	Consultant in expert "hub" provides recommendations and education to the multiple primary care "spoke" clinics	Indirect only for the select patients presented to the team	PCP	During the ECHO series only	Yes	Yes, for geriatric psychiatric disorders and hepatitis C	No
Psychiatric eConsult	Written consultations for individual patients using an online platform	Indirect	PCP	For reviewed cases only	Yes	No	Yes
Psychiatric access lines (child/adult)	Phone consultation; can include some education and care coordination	Indirect	PCP	Yes	Yes	No	No
Store-and-forward (asynchronous) telepsychiatry	Psychiatrist views recorded interviews with patients and makes recommendations	Indirect	PCP	No	Yes	No	No
Single, initial consultation ("one and done")	Provides one-time direct evaluation with recommendations and contingency plans for PCP to implement	Direct	PCP	Sometimes	Yes	No	Yes
Case review with primary care–based team	Remote psychiatrist available for case presentations and education for PCPs	Indirect	PCP	Sometimes	Yes	No	No
Direct patient visits with psychiatrist in primary care	Traditional caseload of patients; direct evaluation of patients in person or by telehealth	Direct	Psychiatrist	Yes	Yes, for those seen, but access to psychiatrist fills quickly	Yes	Yes

[a] PCP, primary care provider.
[b] In direct evaluation, the patient is seen interactively, face-to-face, or by televideo. In indirect evaluation, the patient is not evaluated visually; the psychiatric consultant provides advice and recommendation to the PCP on the basis of information obtained from sources other than the patient.
[c] More capacity is gained in specialty psychiatric care by reducing the referrals for mild to moderate psychiatric conditions.

provider (PCP), they can help build the PCP's competence and capacity while triaging patients who need a higher level of specialty care. The model involves indirect uses of psychiatric expertise via curbside consultations and systematic caseload reviews (4) to improve clinical outcomes and increase PCPs' capacity to treat patients with these conditions. As a result, this model has demonstrated the ability to shorten the waitlist for specialty psychiatric evaluation in primary care (5).

Other models, in addition to CoCM, utilize psychiatric consultants (including psychiatric advanced practice nurses and psychiatric certified physician assistants) to better leverage psychiatric expertise. Not all options have the same

advantages of CoCM, however, and not all are reimbursed by insurance. Table 1 compares CoCM and additional approaches—synchronous, asynchronous, direct (in person or televideo), and indirect (not visually evaluated)—and provides key characteristics of each.

Case-Based Learning

Case-based learning is an important aspect of the consultative approaches that guide PCPs through management of patient care (compared with providing didactic education only). This practice entails applying knowledge to real-world scenarios to help PCPs' understand how to treat psychiatric conditions and apply this learning to patients with similar conditions. We have recognized a noticeable reduction in consultation requests in the 3–6 months after implementation as the learning process takes place, and later consultation requests tend to occur for more complicated presentations. This approach aligns with practices of adult learning theory that demonstrate more effective knowledge gains when learning is applied and not just didactic, thus providing the structure for building the competence of the PCPs requesting the consultation (6).

A best practice approach for effective consultations includes the components of diagnostic clarification, treatment recommendations, contingency planning, and an educational component, done in a collegial manner. The educational component helps explain to the requesting provider why the recommendation was made and further enhances the learning opportunity (7). Encouraging PCPs to use measurement-based care (8) with validated tools to inform progress and promote treatment to defined targets is particularly important in monitoring the effectiveness of care and improves communication about patients' progress.

Experience has shown that PCPs' engagement and follow-through with the psychiatric consultant's recommendations rely heavily on a foundation of trust, which develops over time. In addition, selection of a psychiatric consultant needs to be based on the individual's ability to engage with the team. This standard includes such exhibiting traits such as flexibility, responsiveness to the team, gratification in being part of a team, and being a good and willing educator (9). Suitable psychiatrists have experienced significant job satisfaction and enjoy answering a multitude and variety of questions during consultation (10).

Increasing Access to Traditional Psychiatric Care

Treating in the primary care setting by utilizing psychiatric consultation to assist with treating less severe forms of common conditions or earlier (and more treatment-sensitive) presentations of severe mental health conditions can lead to greater availability of traditional psychiatric appointments for direct evaluation of patients. This approach can address problems with waitlists, timeliness of evaluations, cost of inpatient and emergency room admissions, and suffering that occurs with delays in care. In addition, psychiatric consultants can support PCPs who take stable patients back into their care for refills of psychotropic medications, thereby freeing up even more time for direct psychiatric care and replicating how most of medicine tends to use specialty care.

Limitations and Policy Recommendations

As noted in Table 1, funding for some forms of consultative approaches to leveraging psychiatric expertise are not covered by insurance. There are Current Procedural Terminology (CPT) codes for CoCM, and it is now reimbursed by Medicare, and by Medicaid and commercial insurers in some states, thereby providing a mechanism to pay for the work of added team members, including the psychiatric consultant. These codes provide relative value unit credit for the psychiatric consultant's time spent on the caseload review and team functions, so there is no need for a separate funding source. Another set of codes covers interprofessional internet and telephone consultation, but these codes are used infrequently due to lack of reimbursement by some payers, low reimbursement rates, and the requirement for patient copays and consent. Value-based payment arrangements could result in less dependence on CPT codes and a greater focus on reducing costly specialty care and emergency room and inpatient visits, thus providing reimbursement for the psychiatric consultant through overall cost savings and performance incentives.

Liability concerns may lead psychiatrists to resist providing indirect consultation. In addition, obtaining licensure in the state where the patient (or the caseload registry) is located is recommended, so barriers to consultation across state lines must be addressed. To guide psychiatrists, the American Psychiatric Association has developed a resource document for cross-state consultation to guide psychiatrists (11), which is available online. Lastly, PCPs often have liability concerns about adopting a model of care where they are the prescribers of psychotropic medications and express reluctance to do so. Addressing this issue will require a skilled psychiatric consultant who understands the need to build a trusting relationship with PCPs and utilizes an educational approach to guide them through this initial resistance.

Training enough psychiatric consultants to meet demand is an important aspect because this is a different approach to patient care than is currently taught in most residency training programs. However, many newly trained psychiatrists who are expressing interest in the shift to a more consultative approach are enthusiastic about practicing a form of effective psychiatric care that keeps them connected to their colleagues in other medical specialties.

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REFERENCES

1. The Psychiatric Shortage: Causes and Solutions. Washington, DC, National Council for Behavioral Health, 2017. https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf
2. 2019 Review of Physician and AP Recruiting Incentives. Irving, TX, Merritt Hawkins, 2019
3. Archer J, Bower P, Gilbody S, et al: Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev 2012; 10: CD006525
4. Bauer A, Williams M, Ratzliff A, et al: Best practices for systematic case review in collaborative care. Psychiatr Serv, 2019; 70:1064–1067
5. Kinnan S, Emerson M, Kern J, et al: How a health center eliminated the waiting list for psychiatric services. Psychiatr Serv, 2019; 70:1176–1179
6. Knowles M: The Modern Practice of Adult Education: From Pedagogy to Andragogy. Englewood Cliffs, NJ, Prentice Hall Regents, 1970
7. Raney LE: Integrating primary care and behavioral health: the role of the psychiatrist in the collaborative care model. Am J Psychiatry 2015; 172:721–728
8. Fortney, Unutzer et al: The tipping point for MBC in behavioral health; Psych Serv 2016; 68:179-188
9. Whitebird RR, Solberg LI, Jaeckels NA, et al: Effective implementation of collaborative care for depression: what is needed? Am J Manag Care 2014; 20:699–707
10. Ratzliff A, Norfleet K, Chan YF, et al: Perceived educational needs of the integrated care psychiatric consultant. Acad Psychiatry 2015; 39:448–456
11. Resource Document on Across State line Psychiatric Consultation Considerations: Addendum to Risk Management and Liability Issues in Integrated Care Models. Washington, DC, American Psychiatric Association, 2019. https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/resource-documents

Submissions Invited for Culture & Mental Health Services Column

A new column in *Psychiatric Services,* Culture & Mental Health Services, edited by Roberto Lewis-Fernández, M.D., aims to clarify the ways that culture shapes the utilization, delivery, and organization of mental health services. Submissions may examine the influence of culture at the level of the individual seeking care (e.g., the impact of a person's cultural views of illness on treatment choice and level of engagement), the provider (e.g., the role of implicit racial-ethnic biases on service recommendations), the program (e.g., how local socioeconomic and organizational factors influence the package of services offered at a clinic), or the mental health system (e.g., how political forces affect reimbursement structures that determine availability of services). Dr. Lewis-Fernández welcomes papers that focus on aspects of culture related to interpretation (meaning making), social group identity (e.g., race-ethnicity, language, and sexual orientation), and social structures and systems. The goal of the column is to make visible the social-contextual frameworks that shape care. Papers, limited to 2,400 words, may be submitted online as columns via ScholarOne Manuscripts at mc.manuscriptcentral.com/appi-ps. The cover letter should specify that the submission is for the Culture & Mental Health Services column.