Collaborative Care Model for Bipolar Depression and Schizophrenia in the Institution

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Disclosures

- None
- Thanks to Curtis Wittmann, M.D., Associate Director of the MGH Acute Psychiatry Service, and Jeff Huffman, M.D., Associate Chief for Clinical Services.

Bipolar Disorder and Schizophrenia

- Chronic conditions
- Often debilitating with acute crises
- Successful treatment looks beyond the acute crisis—The Band-Aid—towards chronic care
- Addressing issues beyond the basic medical decisions is essential to recovery

Collaborative Care Model

- Care coordination and case management
  - Addresses social difficulties frequently associated with these conditions
  - Eases navigation of complex systems
- Treatment with active monitoring
  - Use of scales
- Specialty care available
  - Referral when a lack of improvement

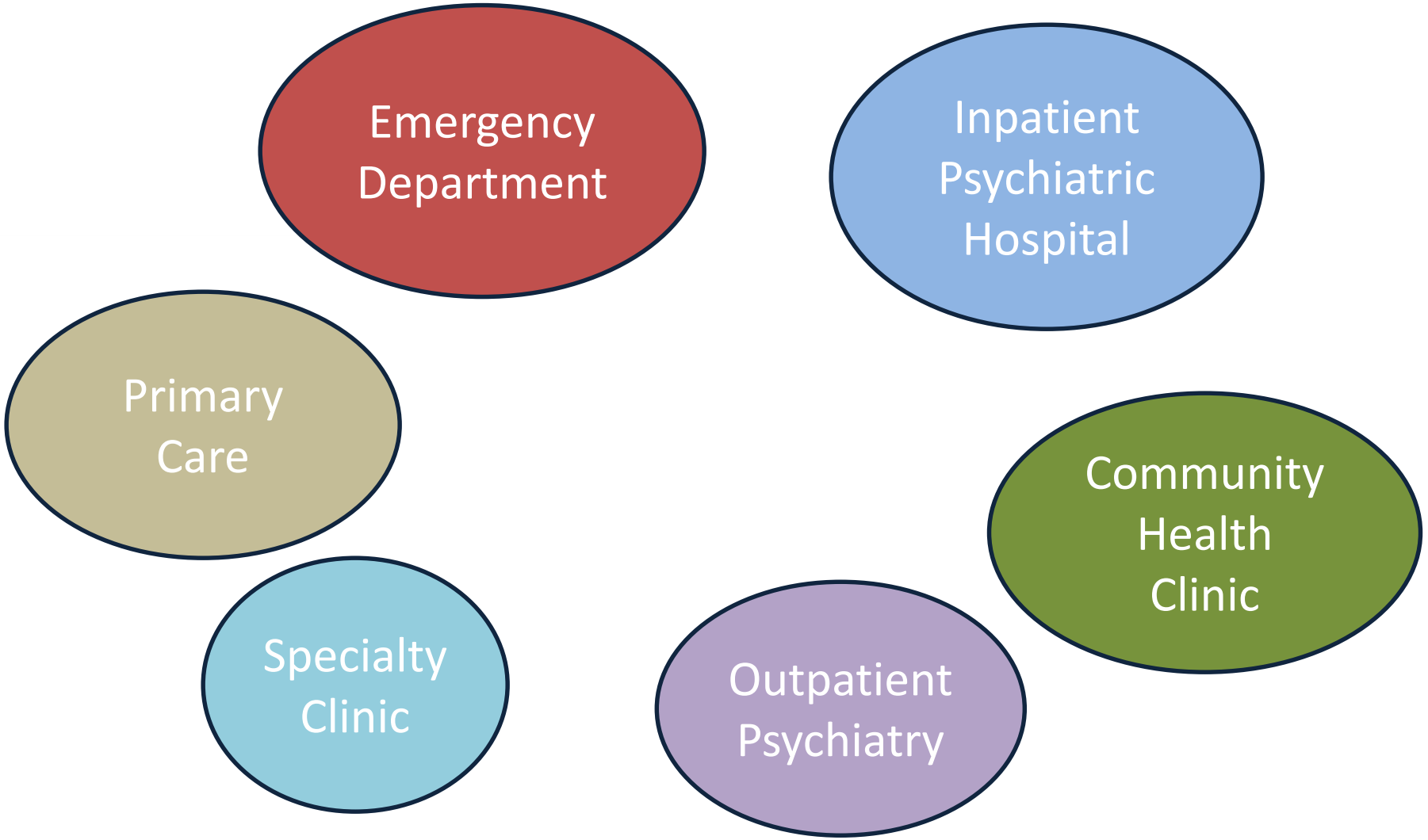
Traditional Model of Care

- Focused on management of acute illness
- Fragmented care
  - Patients seek care across many systems
  - Providers do not always know when someone else is seeing a patient
- Limited time and resources for care coordination

Goals

- Review the settings of care from a provider perspective
- Identify communication challenges in the traditional care model
- Describe strategies to facilitate communication and move towards a collaborative care model

Settings of Care



Emergency Department

- Often the initial point of care
  - Patients and families recognize something is wrong, but do not know where to turn
- Safety Net
  - People do not know where to turn
- Varying levels of expertise
  - Emergency Medicine physician
  - Psychiatrist
  - Social Worker

Emergency Department

- High volume and high acuity
- Limited knowledge of and limited relationships with patients
  - Unknown history
  - Unknown coping styles
- Limited referral resources
  - Hospitalization
  - Partial Hospitalization
  - Outpatient care

Emergency Department

- Focused care
  - Diagnosis
  - Treatment/Disposition
- Safety trumps all
- PRN communication
  - Evaluation and decision making is a rapid process by necessity
  - Providers may or may not be called as clinically indicated

Emergency Department

- Challenges to communication in this treatment setting
  - Volume of patients and the pace
  - Availability of outpatient providers
    - Visits often occur after hours
    - Many providers do not have a reliable way to contact them after hours
  - Patients do not always know the names or numbers of providers

Emergency Department

- What is gained when care is coordinated?
  - The longitudinal perspective
  - Pre-existing management plans
  - The opportunity for close follow-up
  - The opportunity for coordinated inpatient admissions

Inpatient Psychiatric Hospitalization

- Locked units that may be general (any diagnosis) or specialized units
- May or may not be a part of a hospital system
  - Outpatient providers are often not a part of the same hospital system
- Electronic medical records may or may not be visible to other parts of the system
  - Privacy concerns may lead to restricted notes

Inpatient Psychiatric Hospitalization

- Acute care focused on rapid stabilization and step down
  - Hospital Length of Stay is closely monitored
  - Pressure for shorter lengths of stays
- Interventions designed for rapid effect
  - Medication and non-medication
- Multidisciplinary team
  - Physician, case management, social work, and nursing

Inpatient Psychiatric Hospitalization

- The medical records:
  - Medications
    - Dose adjustment
    - Additions
    - Discontinuations
  - Critical Events
    - Restraints
    - Suicide attempts
- Coordinated aftercare
  - May or may not involve physician contact

Partial Hospital

- Outside of the hospital system
- 6-8 hours of treatment a day
  - Most commonly occur during working hours
- Patients are not admitted to the hospital and stay at home
  - Increased freedom
  - Begin to confront stressors not present in hospital
- Types of interventions
  - Group therapy (primary treatment modality)
  - Individual Therapy
  - Medication Adjustment

Partial Hospital

- Psychiatrist
  - Overseeing care
  - Often limited contact with patients
- Psychologists
  - Performing individual work
  - Leading groups
- Social Workers
  - May perform similar tasks as psychologists
  - Case management and aftercare

Partial Hospital

- Programs typically last 2 weeks
- Often used as aftercare/step-down from inpatient hospitalization
- Can be used instead of hospitalization
  - If safety is not an issue
- Communication with key outpatient providers typically occurs, often triggered by acute events
  - PCP may not be aware of partial admission
- Patients may not attend

Primary Care

- Physician who oversees patient's health and manages many conditions
  - Average U.S. PCP panel size is 2300

    Alexander GC, Kurlander J, Wynia MK. Physicians in retainer ("concierge") practice. A national survey of physician, patient, and practice characteristics. J Gen Intern Med. 2005;20(12):1079–1083
- Responsible for coordination of care amongst specialists
- Limited familiarity with and training in mental health issues

Primary Care

- Significant disparities are present in health care outcomes
  - Testing and monitoring
  - Prescribing
- Significant physical health consequences of many psychiatric medications
  - Metabolic syndrome
  - Long term side effects
- Varying degrees of coordination occur

Primary Care

- Coordinating care for all body systems
  - Each one has significant needs
- Small interventions requiring short amounts of time are amplified by patient numbers
  - 3-5 minutes extra per patient can be 2 or more hours by the end of the day
- Medical record integration is helpful if providers are within the same system

Hospital System

- Presence of primary care and specialists in one system
  - Opportunity for connected care
- Large systems with multiple sites
  - May have limited in person interaction between specialties
- Potential for integrated medical record
  - This is passive communication and requires someone to look for it
- Improved ability to refer
- Good support services

Community Health Clinic

- Often a part of a hospital system
  - Unified, visible electronic medical record
- On site mental health and primary care
  - Psychopharmacology
  - Psychotherapy
- Opportunity for well-integrated care
  - Repeated contacts with the same providers
- Opportunity for education between specialists and PCPs

Specialty Clinic

- Clinicians who are expert in bipolar disorder or Schizophrenia
  - Increased awareness of best practices
- Often involved in research
  - Protocols may provide additional support
- Integrated psychology staff can provide psychotherapy
  - Improved communication between providers
  - Opportunities for discussion about challenging cases

Moving towards Collaborative Care

- Insurance
  - Massachusetts and Federal laws
  - Improvement in coverage of previously uncovered coordination services
- Electronic health record
  - Central repository for critical patient information
  - Reminders
  - Secure communications
- Increasing access to providers
  - Telepsychiatry

Collaborative Care at MGH

- Collaborative Care
  - Team consisting of a behavioral health specialist and supervising clinicians
  - Provide support to primary care physicians for straightforward psychiatric conditions
  - Services offered:
    - eConsults
    - iCBT
    - Traditional Collaborative Care

Collaborative Care at MGH

- Team-based Outpatient Psychiatry (TOP)
  - Designed to provide a broader range of treatments
  - Team consisting of a social worker, psychiatrist, nurse practitioner, psychologist, and medical assistant
  - Services offered:
    - Timely evaluations
    - Short course of psychotherapy
    - Medication management
    - Case management
    - Assistance with referrals

The Future

- Continued changes to reimbursement
- Identification of opportunities for support staff to improve provider communications
- Virtual meetings triggered by critical patient events
- Electronic medical record prompts for communication with multiple providers ordering tests or prescribing
- Electronic reminders for communication