

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

2.10 PARAMETERS FOR PSYCHIATRIC CONSULTATION

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I. INTRODUCTION

The integration of Mental Health with Primary Care and innovations in technology have broadened the scope of psychiatric consultation. These parameters discuss direct and indirect (See reference 1) consultation along with role and documentation considerations of each.

II. DEFINITIONS

A. Direct Consultation

1. Provided upon request from a clinician who has direct responsibility for the care of a patient/client;
2. Based upon direct patient/client evaluation; and
3. Completed for purposes of assessment and initiating treatment, referrals or recommendations for mental health treatment.

B. E-consultation

Direct or indirect consultation employing digital and primarily web-based technologies involving such services as tele-medical evaluation, tele-psychiatry (Reference 2.), web-based reviews of clinical records, web-based consultation with clinicians, caregivers and patients/clients, and other related practices.

C. Indirect Consultation

1. Provided upon request from a member of the mental health and/or physical health care treatment team with responsibility for the care of a patient/client;
2. Not based upon direct patient evaluation and therefore not involving a physician/patient relationship; and
3. Completed for purposes of development and implementation of treatment plans.

III. THE ROLE OF THE CONSULTANT

A. Direct Consultation

In direct consultation, the consultant:

1. Receives a request from a clinician with responsibility for a patient's/client's care to

consult with the patient/client;

2. Provides a face to face assessment, in person, or through e-consultation; and
3. Provides a summary of findings and/or actions taken to the referring clinician and retains a copy for his/her records.

B. Indirect Consultation

In indirect consultation, the consultant

1. Receives a request from a member of a mental and/or physical health treatment team with responsibility for care of one or more patients/clients to review various aspects of patient/client care for the purposes of evaluation, recommendations, linkage or initiation of psychiatric treatment;
2. Does not participate in face to face assessment of a patient/client; and
3. Often develops an ongoing relationship with the mental and/or physical health treatment team for purposes of better integrating care through such mechanisms as:
 - a. Being available through phone or other means within agreed-upon times for consultation regarding emergent issues;
 - b. Communicating regularly with the team to provide input on a caseload of patients/clients who are receiving mental health services, reviewing all patients who are not improving clinically and making treatment recommendations to the team or specific team members;
 - c. Reviewing information about assessments and scores from screening instruments utilized to monitor the progress of a team caseload;
 - d. Identifying possible care challenges with specific patients/clients on the caseload of a clinical team and requesting, when appropriate, additional information in order to make further recommendations;
 - e. Requesting additional information when there is insufficient clinical response, e.g. what is the current medical condition or other factors present or ask the Care Manager to consult with the Primary Care Physician;
 - f. Communicating directly to the mental and/or physical health treatment team regarding patients/clients who are not improving in order to provide:
 - I. Brief medication instruction/protocols;
 - II. Information on medication monitoring and titration; and/or
 - III. Suggestions regarding alternative strategies; and
 - g. Providing non-patient/client specific information related to Mental Health treatment to a physical health care provider/team through Webinar or in person at provider meetings.

IV. DOCUMENTATION CONSIDERATION

A. Locus of Documentation

The locus of direct and indirect consultation documentation requirements are determined by applicable Departmental policy, (Reference 3.) and will usually be in the clinical record maintained by the consultant's organization, with copies to the primary care clinical team's organization, when the primary care clinical team's organization is different.

B. Structure of Documentation

1. Direct Consultation

The consultation note should address all requested domains of the consultation, e.g. assessment, diagnostic impression, recommendations for treatment, follow-up recommendations the consultant is willing to provide or recommendations for other referrals.

2. Indirect Consultation

The consultation note in this arrangement is generally brief and tightly focused on the mental and/or physical health treatment team's concerns. The Consultant should:

- a. Provide a structured consultation note that includes a framework for providing information back to the mental and/or physical health treatment team. An identifying statement that succinctly summarizes the patient's/client's presenting condition and the referring clinician's reason for consultation should be present.
 - i. Use language and terminology that is clear and understandable to non-mental health providers.
- b. Include a "Disclaimer" that clarifies the indirect nature of the consult such as:

"These recommendations/suggestions are based on conversation(s) with the patient's DMH care manager only. The consultant has not personally examined the patient/client. (Additionally, in some cases laboratory studies or other information from the primary care medical record that would be relevant were not available at the time of consultation). All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to contact the care manager with questions about the care of this patient/client."

REFERENCES

1. The information regarding the concept for “Indirect Consultation” as defined in these parameters was adapted from the Washington State’s Mental Health Integration Program (MHIP) which incorporates the IMPACT Model for Depression Care, developed by Jurgen Unitizer, MD, MPH, MA, Professor and Vice Chair of the Department of Psychiatry and Behavioral Sciences, University of Washington. (See Attachment I. for URLs and synopsis of key elements of both the MHIP and IMPACT Model)
2. [DMH POLICY 202.36 THE USE OF TELEPSYCHIATRY](#)
3. [DMH POLICY 104.8 CLINICAL RECORD GUIDELINES: CONTENTS AND GENERAL DOCUMENTATION REQUIREMENTS](#)

BRIEF DESCRIPTIONS OF THE MENTAL HEALTH INTEGRATION PROGRAM (MHIP) AND THE IMPACT MODEL FOR DEPRESSION CARE.

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I. Mental Health Integration Program (MHIP)

Excerpted from: [Case Study: Washington State's Mental Health Integration Program \(MHIP\)](http://www.advancingcaretogether.org/pdfs/Case%20Study%20MHIP_updated.pdf)
http://www.advancingcaretogether.org/pdfs/Case%20Study%20MHIP_updated.pdf

Care Team:

Primary Care Providers, Care Coordinators, Consulting Psychiatrists, and other clinic-based mental health providers

Care Model:

- Team approach based on the IMPACT^{II} model of collaborative care
- Comprehensive clinical assessment for every patient
- Use of appropriate symptom measures (e.g., PHQ-9, GAD-7) during follow-up visits to gauge progress and need for treatment changes
- Web-based registry to track a caseload of patients in each clinic to make sure patients don't fall through the cracks
- Care coordinator engages patients and provides close follow-up to support treatment and facilitate changes in treatment
- Designated psychiatrist consults with care manager and primary care provider on the care of patients who do not response to initial treatments
- Referral to community mental health center if patient not responding to treatments in primary care

II. IMPACT MODEL FOR DEPRESSION CARE <http://impact-uw.org/about/key.html>

Five of the most essential elements are:

1. Collaborative care is the cornerstone of the IMPACT model and functions in two main ways:
 - The patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy)
 - Care manager and primary care provider consult with psychiatrist to change treatment plans if patients do not improve
2. Depression Care Manager:

This may be a nurse, social worker or psychologist and may be supported by a medical assistant or other paraprofessional. The care manager:

- Educates the patient about depression
- Supports antidepressant therapy prescribed by the patient's primary care provider if appropriate
- Coaches patients in behavioral activation and pleasant events scheduling
- Offer a brief (six-eight session) course of counseling, such as Problem-Solving Treatment in Primary Care
- Monitors depression symptoms for treatment response
- Completes a relapse prevention plan with each patient who has improved

3. Designated Psychiatrist:

- Consults to the care manager and primary care physician on the care of patients who do not respond to treatments as expected

4. Outcome measurement:

- IMPACT care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter. We recommend the PHQ-9 as an effective measurement tool, however, there are other effective tools.

5. Stepped care:

- Treatment adjusted based on clinical outcomes and according to an evidence-based algorithm
- Aim for a 50 percent reduction in symptoms within 10-12 weeks
- If patient is not significantly improved at 10-12 weeks after the start of a treatment plan, change the plan. The change can be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist.