The Role of the Psychiatrist in Perinatal Collaborative Care

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PERINATAL COLLABORATIVE CARE COLLECTIVE

Not Your Usual Psychiatric Care!

- In day-to-day practice, many psychiatrists practice very differently from physicians in other specialties
- They typically spend more time per patient, cannot bill for procedures, and do not have the ancillary help (such as medical assistants, scribes, etc.) that is common for other physicians
- Referrals often come through non-traditional means, and case discussions and notes tend to be long and thorough
- If you try to operate within the CCM as a typical psychiatrist, it will not work!

Overview of the Psychiatrist Role

Consultant

You will hear cases presented by other team members, and you will review charts

You will rarely see patients directly

Educator

At the outset, you will be the only one on the team with in-depth knowledge of psychotherapy and psychopharmacology

Part of your job is to educate both care managers and obstetric clinicians about these topics

Team Leader

You are the person on the team who needs to take responsibility for any urgent or emergent situations – the buck stops with you. You must also champion the model and sing its praises to your OB colleagues, who may require time and experience to feel comfortable integrating mental health into their care model

Necessary Attributes

Good cheer!

Flexibility

Able to task-shift quickly and manage interruptions

Not risk-averse – must be willing to render judgements on cases with less comprehensive information

Facile with the electronic health record, willing to write short and formulaic notes, and respectful of interdisciplinary expertise

A thick skin – OB providers are busy, stretched thin, and often reluctant to add this care to what they do. A psychiatrist who is easily offended would not be a good fit.

How Does the Psychiatrist Spend Her Time?

Indirect consultation

- Vast majority of time spent on this. Includes hearing presentations from care managers, chart review, and provision of recommendations to OB provider. Can occur during case review meeting or outside of it.

Direct consultation

- Rare, about 5% of patients. Used when need for diagnostic clarification or when patient is not improving with other strategies.

Systematic case review

- Weekly review of measurement-based care instruments and review of new or not-improving cases; indirect consultation can be part of this

Supervision and education

- In some programs, trainees in psychiatry or OB may rotate to learn any of the above tasks.

Liability Concerns

A CCM psychiatrist is providing recommendations for patients she has never seen – that can be scary!

It is important to avoid establishing a doctor-patient relationship

That means that all direct care MUST be in the hands of the care manager and of the obstetric clinician. The psychiatrist should not be ordering labs, tests, or medications – these must be done by the obstetric clinician.

When recommendations are provided, they are documented in the medical record as the recommendations of a consultant; it is up to the obstetric clinician to act on them or not

Is the Psychiatrist in Charge of the Program?

That depends! Usually on whose idea it was to start the program ….

The cleanest structure is for the care managers NOT to be supervised by the psychiatrist, and for program management NOT to be in the hands of the psychiatrist

That allows the psychiatrist to serve purely as a consultant; it reduces liability and provides leadership opportunities for others

But that will not always be possible …

Creator of Resources

It is crucial for the psychiatrist to oversee the creation of educational materials for care managers and OBs

These can be drawn from this website or other resources and adapted for your particular setting

Creating a safety protocol for OB practices is very important

Creating multiple templates for use by psychiatric consultants, OB clinicians, and care managers will streamline your flow

What Do I Need to Know about Billing?

Not much!

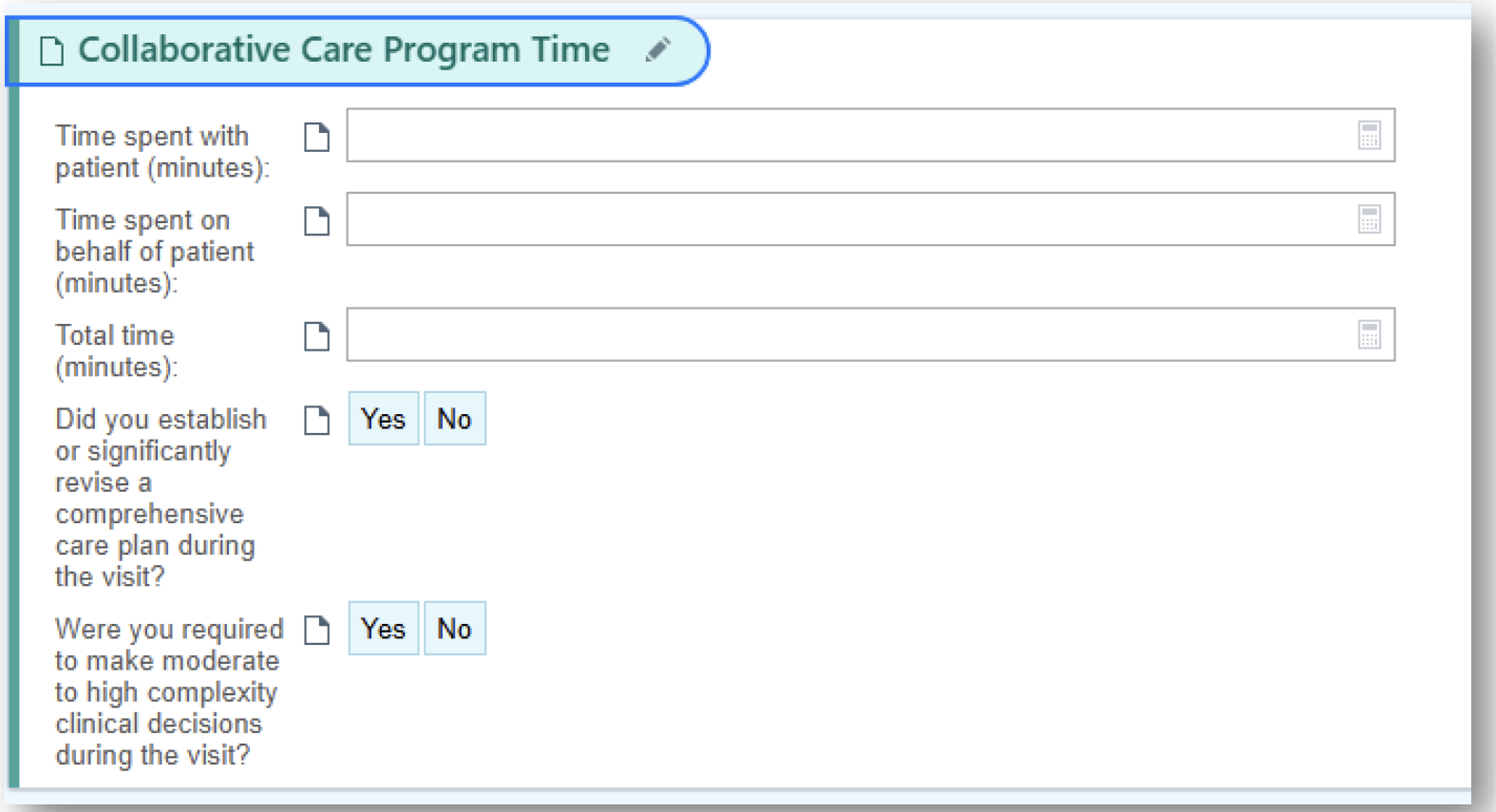
Bills for CoCM go through the obstetric clinician, not you

You will need to keep track of all the time you spend, because that gets added to the care manager's time to be billed on a monthly basis

This can be done with a SmartForm in your EHR; if not available, you can track in other ways and provide total amount to care manager on a monthly basis

If you perform DIRECT consultation (i.e., face-to-face patient time), you will need to bill your usual psychiatric office visit codes

Example Templates: SmartForm for Capturing Time



Example Templates: Psychiatric Consultation Note

- Hello [PCP NAME],
- I had the opportunity to discuss your patient, [NAME], with the clinic's behavioral health care manager, [NAME], in our weekly clinical meeting. Please see below for my recommendations. Please feel free to contact me with any further questions.
- **Brief Summary**
- **Recommendations**
- Behavioral health care manager, [NAME], will continue to follow patient for symptom monitoring and support.
- **Possible Side Effects**
- **Scores**
- EPDS:
- MDQ:
- **Background and Decision-Making**
- **Safety Concerns**
- **Substance Use Concerns**
- **Previous Medication Trials**
- The above treatment considerations and suggestions are based on consultation with the behavioral health care specialist and a review of information available in the chart. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient.
- [PSYCHIATRIC CONSULTANT NAME]
- Pager: 55555

Example Templates: Medication Titration

Patient would benefit from initiation of an SSRI; you can start with any SSRI (see our FLIPP guide for further information), but in absence of patient or provider preference you can begin with sertraline:

- Begin sertraline at 25 mg PO daily x 4 days (to assess side effects and tolerance)
- Day 5, increase to 50 mg
- Assess symptoms every 2-4 weeks thereafter prior to additional titration

Example Templates: Risk Discussions

Risk-Risk Conversation

Risks of psychopharmacological treatment vs. risks of untreated psychiatric illness in pregnancy and lactation were discussed with the patient in today's session. Recommendations were made based on current medical evidence. Risks of SSRIs discussed include (but are not limited to) risk for preterm birth, poor neonatal adaptation, persistent pulmonary hypertension. Risks of untreated mental illness include (but are not limited to) risk for preterm birth, substance use, poor prenatal care and nutrition, low birth weight, higher neonatal cortisol, increased internalizing and externalizing disorders for the child, and postpartum depression (with risks for mother of increased burden of psychiatric illness and for child of lower IQ, slower language development, and child psychiatric illness).

Suicide/Self-Harm Risk

This patient has *** chronic risk due to her *** (with *** acute risk) of self-harm due to her ***. I have personally evaluated this patient's personal history and concerning factors that increase (history of attempts, access to lethal means) and mitigate (e.g. strong family supports, positive coping skills, demographic features) suicide risk in this patient in formulating the patient's current risk profile. This assessment will be revised based on the patient's clinical condition and any new personal or environmental variables that are discovered or arise.

Additional Resources

- This key article in the American Journal of Psychiatry lays out the psychiatrist role in collaborative care generally
  - https://psychiatryonline.org/doi/pdf/10.1176/appi.focus.15305
- The American Psychiatric Association offers great training in the CC model (again, geared to primary care) as well as publication on how to adapt the model for the perinatal population:
  - https://education.psychiatry.org/Public/Catalog/Details.aspx?id=67obpHn%2byW%2fqCS86V5qZ7A%3d%3d&returnurl=%2fUsers%2fUserOnlineCourse.aspx%3fLearningActivityID%3d67obpHn%252byW%252fqCS86V5qZ7A%253d%253d
  - https://www.psychiatry.org/getmedia/e2eafc40-965c-4a72-b206-50b458c35e16/APA-Treating-Perinatal-in-the-CoCM-Guide.pdf
- ACOG offers general resources for integrating mental health into obstetric settings
  - https://www.acog.org/programs/perinatal-mental-health/integrating-mental-health-care-into-ob-practice-guide
- Additional???

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