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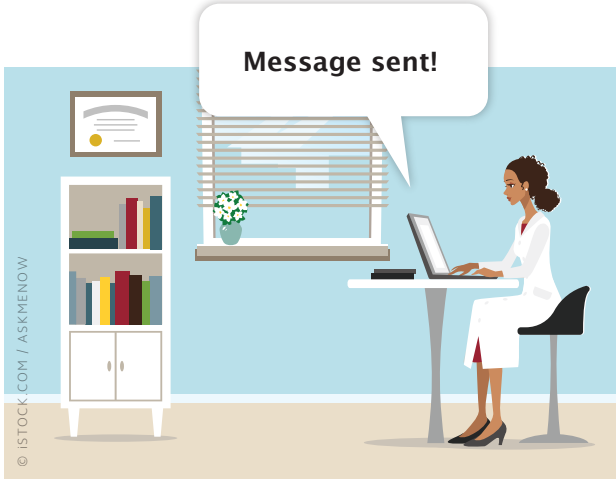
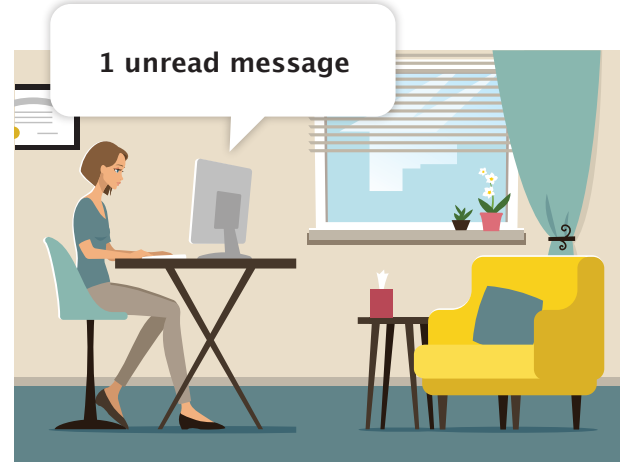
Psychiatric e-Consults: A Guide for the Referring Physician





Electronic consultations can help primary care physicians manage behavioral health conditions more efficiently and effectively. Here's how.

Nearly 20% of all adults meet the criteria for a psychiatric disorder,[1] and with psychiatric specialists in short supply,[2] primary care physicians play an essential role in managing their patients' mental health.

But primary care physicians need not do this alone. Electronic consultations (e-consults) can provide valuable support, especially for those who don't otherwise have access to psychiatrists or other behavioral health professionals in their community. All e-consults are not equally effective, however. This article explains the purpose of psychiatric e-consults, based on our collective experience using them for many years, and provides advice on how to make the most of them.

WHY USE E-CONSULTS?

E-consults are asynchronous clinician-to-clinician communications, ideally within a shared electronic platform. Unlike a traditional consultant, the e-consultant answers the primary care physician's questions without meeting or interviewing the patient,

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relying solely on information the referring physician shares, often via the EHR or e-consult platform.[3] E-consult use has been increasing in several specialties.[3,4]

In one study, more than 90% of primary care physicians who used e-consults said they are helpful and improve patient care, and more than 80% said using e-consults increased their own behavioral health knowledge.[5] In another study, e-consult users said they implemented at least one of the consultants' recommendations up to 94% of the time.[6] E-consults are associated with reductions in psychiatric specialty care costs, face-to-face behavioral health visits, and treatment delays.[7,8,9] Overall, consultant response times average 1-3 days, and consultants can respond to some questions much faster, sometimes in a matter of minutes.[6]

> The psychiatric specialist's opinion adds weight that gives the primary care physician and patient more confidence.

In addition to being supported by data from published studies, psychiatric e-consults have proven useful for our institution through countless anecdotes. We have seen patients referred for in-person psychiatric intake have their symptoms fully resolve before their intake date because their primary care physician implemented an e-consultant's recommendations. Our primary care physicians have effectively treated refractory depression and tapered controlled substances such as zolpidem or benzodiazepines with e-consult support.

KEY POINTS

- Psychiatric e-consults are a valuable resource, especially for primary care physicians and patients who have limited access to psychiatrists or behavioral health professionals in their communities.
- E-consults are more effective when the referring physician asks the consultant specific questions, includes a comprehensive note, uses mental health screening tools, and makes visit documentation easy for the consultant to navigate.
- E-consults are billable and include work relative value unit credits for the consultant and the referring primary care physician.

While there are instances when patients do not agree to the consultant's recommended treatment (especially if side effects such as weight gain are likely), in general, patients accept psychiatric specialists' recommendations. Even when the e-consultant advises continuing the treatment plan the primary care physician is already suggesting, the psychiatric specialist's opinion adds weight that gives the primary care physician and patient more confidence in it. If the patient does not accept the e-consultant's primary recommendation, or does not benefit from it, most high-quality e-consults include contingency plans primary care physicians can try.

MAKING E-CONSULTS WORK FOR YOU

Despite their many benefits, psychiatric e-consults have limitations. Behavioral health interviews are detailed and comprehensive, assessing multiple potential psychiatric diagnoses, prior treatment trials, complex biopsychosocial interactions, and the pros and cons of various treatment options. E-consults do not allow for such detailed assessments.

Given the complexity of psychiatric care, e-consults are most useful when primary care physicians optimize the questions they ask and the information they give to the consultant (see "Tips to make psychiatric e-consults more effective").

1. Avoid vague statements and questions. Requests such as "Patient with depression and anxiety; please recommend next steps" should be avoided in favor of more specific requests such as "Patient has felt no symptom relief from medications X or Y. Can you recommend another?" (See "Sample e-consultation" on page 12.) A focused clinical question combined with relevant clinical information will result in a more detailed and specific consultant response.

2. Write a comprehensive note before submitting the e-consult request. A note that simply says the patient has "depression and anxiety" and has tried and failed "multiple antidepressants" does not give the consultant much to go on. But if the referring physician documents known treatment trials, this can prevent the consultant from recommending first-line

treatments the patient has already tried with no benefit.

3. Use common mental health screening tools and patient-reported outcome measures (PROMs). These tools can help the referring physician gather clinical information and aid the consultant in considering a diagnosis and treatment plan. (See "Common behavioral health screening tools" on page 13.) Screenings provide data about what conditions patients may have. The results of these screenings alone are not sufficient to make a formal psychiatric diagnosis, but an experienced e-consultant can often combine them with other information in the chart to form a diagnostic assessment and treatment plan. PROMs provide data about the stability of a patient's general mental health or specific mental health conditions, which can help the consultant refine the plan. In addition, treatment algorithms and laboratory monitoring guidelines for common psychiatric drugs can aid primary care physicians in treating patients with psychiatric disorders.[10] (See "Common psychiatry treatment guidelines.")

4. Make your visit documentation easy to navigate. Effective psychiatric e-consults often require a more in-depth chart review than in-person evaluations, where the patients themselves are the primary source of clinical information. If the requesting physician is aware of important documentation in the chart, pointing the consultant to those notes is especially helpful because that information may be buried by other notes, especially for patients with complex medical histories.

5. Include pertinent information about biological, psychological, and social determinants of health. Psychiatric consultants often use this information when forming a diagnosis and treatment plan. For example, if the patient is a young college student who has been increasingly irritable and impulsive, the consultant is likely to recommend different treatment options if the student has a family history of bipolar disorder than if the student has been using illicit drugs.

6. Find an e-consult platform that allows for easy information-sharing. At our institution, we use a shared EHR system. It helps ensure high-quality e-consults by monitoring the timeliness of the consultant's response, whether the consultant directly answered the primary care physician's question, the resources or clinical rationale to support the recommendations, and whether the consultant included contingency measures should the initial recommendations be ineffective. For those without a shared EHR, for-profit e-consult platforms allow primary care physicians (for a fee) to work with e-consult specialists outside their institution. E-consults done outside a shared EHR or e-consult

TIPS TO MAKE PSYCHIATRIC E-CONSULTS MORE EFFECTIVE

Tip	Example
Be specific with the request.	Include the reason for the e-consult and what kind of recommendations you are seeking. Avoid vague questions.
Offer objective data when available.	Include pertinent symptoms in the referral question or indicate where that information can be found in the chart (e.g., phone note or recent office visit).
Use validated rating scales or patient-reported objective measures.	PHQ-9, GAD-7, ZAN-BPD, or MDQ (see "Common behavioral health screening tools" on page 13 for more examples).
Include pertinent history or risk factors that may affect diagnosis.	Family history of bipolar disorder, childhood history of trauma, prior history of symptoms concerning for mania, etc.
Include concurrent use of substances or other important collateral information.	Recent use of illicit drugs or alcohol, or an event (such as a relationship break-up) that may have triggered worsening of symptoms.
Include prior treatment trials and responses.	See "Sample e-consultation" on page 12.

COMMON PSYCHIATRY TREATMENT GUIDELINES

- Harvard South Shore Psychopharmacology Algorithms: https://psychopharm.mobi/algo_live/
- MGH Center for Women's Mental Health: https://womensmentalhealth.org/specialty-clinics/
- Canadian Network for Mood and Anxiety Treatments: https://www.canmat.org/resources/

SAMPLE E-CONSULTATION

The following e-consult request from the referring physician is effective because it includes objective data about the patient's symptoms, previous treatment trials (including responses and side effects), relevant patient history, and a specific question at the end. A rating scale produced by a common behavioral health screening tool may have added strength to this request, but it isn't absolutely necessary because the physician has included enough other information for the consultant. It would be important for the referring physician to also include any additional pertinent information, such as the use of alcohol or illicit drugs.

Referring physician request:

25-year-old female with history of depression and anxiety has reported worsening insomnia and anxiety despite current antidepressant treatment. Patient previously tried sertraline, which was discontinued due to nausea. She is now taking fluoxetine, which has been increased to 40 mg daily without side effects. She feels that this medication was initially helpful for anxiety and mood but has been less effective recently with new onset insomnia in the context of increased stress at her job. Patient does not have any known family history of psychiatric illness or history of mania. Do you recommend medication adjustment or transition to alternative medication?

Consultant's recommendations:

Consider optimizing fluoxetine. The patient can increase to 60 mg daily to target mood and anxiety symptoms and titrate to effect with maximum daily dose of 80 mg daily (https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/018936s108lbl.pdf).

Encourage engagement in evidence-based psychotherapy to build coping skills given current psychosocial stressors.

Rationale and/or evidence for recommendation:

It is not unusual for patients to report SSRIs have become less effective over time at a given dose, particularly in combination with new psychosocial stressors. Given the patient's good tolerance and initial positive response to fluoxetine, it would be reasonable to first optimize this medication to target anxiety and mood symptoms prior to transitioning to an alternative medication or considering the addition of another medication. The patient could increase fluoxetine to 60 mg daily and monitor response, with plan to titrate to effect with maximum dose of 80 mg daily. Per chart review, patient has never had any trials of psychotherapy. Evidence suggests combining medications with psychotherapy improves patient outcomes. This patient, therefore, may also benefit from engaging in psychotherapy in combination with medication to build coping skills for her ongoing psychosocial stressors.

Contingency planning:

• If the above recommendations do not yield improvements in anxiety, depression, or insomnia, the patient could consider the addition of mirtazapine at 7.5 mg nightly.

• If fluoxetine is not tolerated at higher doses, consider a transition to an SNRI such as venlafaxine or duloxetine.

platform may be limited by the consultant's lack of access to clinical information and may tend to focus more on education rather than specific clinical recommendations. Adding e-consults into a patient's medical records may also be more challenging without a shared EHR.[11]

CODING, DOCUMENTATION, AND MEDICO-LEGAL GUIDANCE

E-consults are billable and include work relative value unit (wRVU) credits through a series of "Interprofessional Telephone/Internet/Electronic Health Record Consultations" CPT codes that Medicare began accepting in 2019.[12] (See "E-consult codes.") These codes cover the activities of both the primary care physician and the consulting psychiatric specialist. They include parameters for the time spent by each clinician and requirements for the primary care physician to obtain and document the patient's verbal consent to the e-consult and associated co-pays. The relative newness of these codes and the patient cost-sharing requirements have been among the biggest barriers to implementing e-consults so far, but these barriers can be overcome if you know the codes and what to tell your patients about the costs and benefits.[13]

Documentation guidelines for psychiatric e-consults may differ between institutions, but they generally include prompts asking the primary care physician to state a clear consult question with relevant historical information, including medication trials, screening tool results, and concurrent substance use.[9] Documentation templates may auto-populate common screenings (such as the Patient Health Questionnaire-9) and relevant laboratory results.

Standards of care for e-consults are actively evolving, and liability regulations vary by state, so primary care physicians are encouraged to seek guidance from local legal counsel.[14] Generally speaking, primary care physicians and consulting specialists have a shared responsibility to review the available clinical information and base recommendations in sound clinical judgment. But the primary care physician maintains the doctor-patient relationship and should consider the consultant's recommendations within the context of the patient's

COMMON BEHAVIORAL HEALTH SCREENING TOOLS

Screening tool	Acronym	Diagnosis	Source
Patient Health Questionnaire-9	PHQ-9	Major depressive disorder	https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf
Generalized Anxiety Disorder 7	GAD-7	Generalized anxiety disorder	https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf
Zanarini Rating Scale	ZAN-BPD	Borderline personality disorder	https://huibee.com/wordpress/wp-content/uploads/2013/11/Borderline-Personality-Disorder-Scale.pdf
Mood Disorders Questionnaire	MDQ	Bipolar disorder	https://www.ohsu.edu/sites/default/files/2019-06/cms-quality-bipolar_disorder_mdq_screener.pdf
Composite International Diagnostic Interview 3.0	CIDI 3.0	Bipolar disorder	https://www.ohsu.edu/sites/default/files/2021-10/%28CIDI%29%20Screening%20Scale%20for%20Bipolar%20Spectrum%20Disorders.pdf
Abnormal Involuntary Movement Scale	AIMS	Tardive dyskinesia	https://dmh.mo.gov/media/21821/download
Montreal Cognitive Assessment	MoCA	Cognitive impairment	https://www.mocatest.org/paper/
Alcohol Use Disorders Identification Test	AUDIT	Alcohol use disorder	https://nida.nih.gov/sites/default/files/audit.pdf
Drug Abuse Screening Test	DAST-10	Substance use disorder	https://gwep.usc.edu/wp-content/uploads/2019/11/DAST-10-drug-abuse-screening-test.pdf
Adult ADHD Self-Report Scale DSM-5 Version	ASRS-5	Attention deficit hyperactivity disorder (ADHD)	https://www.hcp.med.harvard.edu/ncs/ftpdir/adhd/ASRS-5_English.pdf

overall clinical care. Our institution includes a standard disclaimer at the end of each e-consult that reminds the referring physician of these responsibilities.

Primary care physicians are not obligated to follow the consultant's recommendations and may refer patients for face-to-face psychiatric evaluations as needed. E-consults are not well suited for managing behavioral health crises or unstable psychiatric conditions.

A WIN-WIN FOR PATIENTS AND PHYSICIANS

E-consults improve access to care, with reduced wait times for psychiatric specialist recommendations[15] and high rates of satisfaction among primary care physicians.[3,5] The usefulness of e-consults varies depending on the complexity of the case, specificity of the primary care physician's question, and the clinical information available to the consultant. Their utility increases when the requesting primary care physician includes important information such as pertinent psychiatric history, symptoms, treatment trials, and standardized rating scales.

We have outlined several strategies and resources that, based on our experience, will improve the value of psychiatric e-consults. Many of this article's tips (e.g., "ask a focused clinical question") can also be applied to e-consults with other types of specialists.

When utilized correctly, e-consults increase primary care physician knowledge and comfort in managing psychiatric

E-CONSULT CODES

Consultant codes	Time	Work RVUs*
99446	5-10 minutes	0.35
99447	11-20 minutes	0.70
99448	21-30 minutes	1.05
99449	≥31 minutes	1.40
99451	≥5 minutes	0.7
Primary care clinician code	**Time**	**Work RVUs**
99452	16-30 minutes†	0.7

*Work RVUs listed are from the 2022 Medicare Physician Fee Schedule.
†Consult CPT manual for time exceeding 30 minutes, as these regulations are evolving.

conditions. Given the worsening shortage of psychiatrists, supporting patients and primary care physicians in this way is increasingly important. FPM

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