Comprehensive Care for Complex Patients

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Steven A. Frankel, MD

Clinical Associate Professor, University of California School of Medicine, San Francisco, and Director, Center for Collaborative Psychiatry, Psychology, and Medicine, Kentfield, CA, USA

James A. Bourgeois, OD, MD

Professor, Department of Psychiatry & Behavioural Neurosciences, Michael G. DeGroote School of Medicine, Faculty of Health Sciences, McMaster University, Ontario, Canada

Philip Erdberg, PhD

Assistant Clinical Professor, University of California School of Medicine, San Francisco, CA, USA

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Every effort has been made in preparing this book to provide accurate and up-to-date information which is in accord with accepted standards and practice at the time of publication. Although case histories are drawn from actual cases, every effort has been made to disguise the identities of the individuals involved. Nevertheless, the authors, editors, and publishers can make no warranties that the information contained herein is totally free from error, not least because clinical standards are constantly changing through research and regulation. The authors, editors, and publishers therefore disclaim all liability for direct or consequential damages resulting from the use of material contained in this book. Readers are strongly advised to pay careful attention to information provided by the manufacturer of any drugs or equipment that they plan to use.

Contents

Forewords

There is increasing emphasis on integration of mental health and medical services. Integrated behavioral health models are emerging with compelling evidence for clinical and cost effectiveness. Experts in these models have found that patients in these integrated programs who have highly complex co-morbid psychiatric and medical conditions require additional attention to ensure optimal outcomes.

The authors of this timely text long ago developed a model, through years of clinical experience, to manage these most complex patients. Their proposition is refreshing just in time for an era in which emerging models of accountable care will require novel solutions that engage, embrace, and actively manage complex patients instead of avoiding them and deferring or spinning off their care.

For patients requiring a higher degree of intervention than psychiatric advice, psychiatric consultation, and nurse or social work case management, the notion of the seasoned psychiatrist being the air traffic controller for the patient's overall care, in addition to serving as the treating psychiatrist, is proposed. The authors have studied their outcomes and present them in the text. They provide numerous illustrative case examples of how their psychiatrist-led team approach works with real patients. They describe how the medical psychiatric coordinating physician operates in simultaneous macroscopic and microscopic roles. Their model is compelling; this text is a must-read.

James Rundell, MD
Vice-Chair, Psychiatry and Psychology, Mayo clinic, USA

From my perspective, perhaps the greatest contribution of this book by Frankel, Bourgeois, and Erdberg is its coverage of the "complexity" approach to care. Few physicians, let alone psychiatrists, have an appreciation of the connection between chronic complicated illnesses and non-illness related factors that lead to treatment resistance, persistent illness, high health costs, and personal and functional impairment. This book serves as a primer for psychiatrists interested in addressing the needs of complicated patients at the interface of medicine and psychiatry on complexity theory and the application of assessment techniques that allow medical psychiatric coordinating physicians (MPCPs) or health professionals, such as

care/case managers under their supervision, to connect clinical and non-clinical complexity needs through coordinated service delivery.

I have known Drs. Frankel and Bourgeois for several years, since we all have an interest in improving the care of primary and specialty medical patients with psychiatric co-morbidity. Both are quality physicians and innovative thinkers. Our common interest has led to a number of stimulating discussions about clinical approaches that can be considered for use when health and life complexity overtax standard care capabilities and thus require innovative approaches to reverse persistent health, life, and cost problems. Dr. Frankel has used one such approach for a number of years, i.e., a psychiatrist-centric model in which MPCPs take on the role of physical and mental health team lead for patients with significant psychiatric contributions to their health outcomes. It is this model and the patient cases exposed to it that forms the unique content of this book.

The complexity, rather than a disease, approach to patients described in the book draws on the experience and expertise of a group of researchers in Europe. The INTERMED group has been instrumental in supplying a methodology to health system professionals that allows them to identify patients at high risk for poor outcomes using a multi-domain (biopsychosocial and health system) assessment system. Results of the complexity assessment inform the direction of care delivery needed to reverse poor clinical and cost outcomes. Understanding this concept alone makes this book a valuable read.

Psychiatrists with training in psychosomatic medicine (consultation-liaison (CL) psychiatrists) or those who have completed joint residencies (internal medicine and psychiatry; family practice and psychiatry; psychiatry, child psychiatry, and pediatrics) are an ideal group to take ownership of patients with health complexity, since they have interest and expertise that allows them to take on the role of MPCPs described in the book. While these would be a group for which the book would provide an informative read, general psychiatrists would also benefit, since their roles in the future will include greater clinical activity and a better understanding of psychiatric care in the primary and specialty medical sector. Furthermore, there are far too few CL or jointly trained psychiatrists to assume accountability for medical/surgical patients with complex health needs.

This leads to a discussion of what I consider a major concern associated with use of the MPCP model *per se* as described in the book. The model defines an approach to complex patients with the MPCP at the center of activity, i.e., the coordinator of all care (medical and psychiatric). While this has clear advantages in terms of having a highly qualified practitioner in change, Drs. Frankel and Bourgeois and I have had several debates on just how practical the MPCP approach is, given the short supply of psychiatrists willing to practice in the medical sector, let alone the number of CL or jointly trained physicians. This, along with other factors, could hamper safe, effective, outcome changing, and sustainable implementation, such as: (1) which patients should be targeted for assignment to a MPCP; (2) how the MPCP will interact with primary and specialty care physicians and share responsibility for physical illness decision-making; (3) who will be included among the coordinated

care teams and how they will communicate when not part of a closed system; (4) how many complex patients can be assigned to a MPCP before workload exhausts capacity to create outcome change; and (5) who will pay for the MPCP services delivered at a rate that covers professional costs.

In a sense, the fact that these questions loom is good. Readers will be stimulated to come up with either answers or alternatives to the approach described in the book. Patients with health complexity are clearly a group that requires additional thought by innovative clinicians and health system administrators, since they constitute the small percentage of patients (2% to 10%) that use 30% to 70% of health resources, largely due to poorly treated and thus persistent clinical disorders. New ways to address the health needs of these patients are required. The MPCP model provides one concrete suggestion on how better outcomes for these patients might be addressed. It also stimulates thought about alternatives.

My discussions with Drs. Frankel and Bourgeois have certainly motivated me to think more concretely about substitutes or model offshoots that might be considered as more practical choices for management of complex patients. For instance, there is good data now showing that care managers are effective in reversing complex patient outcomes when supervised by clinicians with the expertise to consider alternative or escalated care when improvement is not occurring. Would routine use of care managers be a logical extension of the MPCP model, allowing expansion of reach for the MPCP to a larger population of patients? These and many other options should be considered as readers peruse this psychiatrist-centric model.

Roger Kathol. MD
Professor of Internal Medicine and Psychiatry, University of Minnesota, USA

Despite the existence of several theoretical and practical approaches for overcoming the mind-body divide, modern medicine is still characterized by fragmented care, particularly for more difficult cases such as those involving chronic and complex illness. These patients typically find themselves deprived of sorely needed comprehensive and personalized care.

With this book, the authors present a new model confronting the challenges of providing care for complex patients with psychiatric comorbidity. It features a physician with a new role, that of the Medical–Psychiatric Coordinating Physician (MPCP). Besides his or her traditional 'microscopic,' specialization i.e. clinical tasks within his or her specialty (psychiatry, internal medicine or family medicine), that physician assumes the 'macroscopic' tasks of actively enhancing interdisciplinary collaboration and leading a multi-professional team. By taking on these roles, that physician becomes a medical and personal guide for that patient and an advocate for his or her health and well-being.

The MPCP model is an appealing contribution to medicine in general and psychosomatic medicine in particular. It keeps up the tradition of George Engel's

bio-psycho-social approach, Michael Balint's understanding of the conscious and unconscious aspects of the doctor-patient relationship, and Viktor von Weizsäcker's patient-centered medicine. Moreover, it's a new and challenging field of work for those physicians (psychiatrists with psychosomatic subspecialization, family physicians or internists) who are interested in a 'holistic' bio-psycho-social understanding of illness, the subjectivity of the ill person within the complex influence of his or her milieu, as well as the intensive communication required in working with medical colleagues and other health care professionals. From my point of view, training in this model of care should be integrated in all psychiatric and primary care programs and fellowships.

However, the book goes far beyond the description of this new "MCPC" model. It offers an in-depth look at the problem of decision-making in medicine with a focus on physician-patient reciprocity. Because all medical treatments are collaborative undertakings, taking account of the subjectivity and inter-subjectivity of the patient's and the physician's experience is indispensable for creating a trusting doctor-patient-relationship and achieving effective clinical outcomes. In their approach, the authors meticulously describe the process of experience-based clinical judgment as a necessary contribution to evidence-based clinical strategy creation. In line with George Engel's appeal for 'looking inside and being scientific,'[1] they advocate a method for clinical accuracy through clinically useful and appropriate 'truing devices.' Such techniques can help the physician better understand and systematically assess the less tangible factors influencing the process of care.

Although this book should be required reading for the health care professional working with psychiatrically and medically comorbid patients, it is worthwhile reading for every physician with a deeper interest in the communication processes with patients as well as for the interested 'lay person'. It is noteworthy that the authors succeed in explaining their approach to complex problems using clear and comprehensible language. Further, it is a pleasure to read the case vignettes illustrating how the MPCP model works in moment to moment patient care.

Wolfgang Söllner, MD
Chief Physician, Klinikum Nürnberg Nord, Germany

[1] Engel G. The need for a new medical model: a challenge for biomedicine. Science. 1997;196:129–136.

Preface

The development of the medical–psychiatric coordinating physician model

I (Steven Frankel) began to develop this model over 20 years ago. My background is divided. As with many psychiatrists of my generation, in addition to psychiatric residency I undertook training and certification in psychoanalysis. I also became interested in developmental contributions to psychopathology and character, and, so, I became board certified in child and adolescent psychiatry. In clinical work with children and adolescents it is not possible to exclude from consideration the ongoing pathogenic influence of the environment, including parents, school, and culture.

At this point, from my practice and my role as a full-time faculty member at the University of Michigan Medical School, I was also becoming aware of the profound limitations of in-depth, interpersonal psychotherapy. Consequently, I began to write about the issue of personal change, change resulting from deliberately orchestrated interpersonal influence.

In short, I was continually propelled to develop a way of organizing treatment that encompassed all pertinent factors: biological, temperamental, psychological, environmental, and developmental. To be true to life none of these influences could be excluded from clinical consideration. To be operational, the model needed ways to prioritize contributing factors and select interventions. Algorithms, while quite useful, tend to be inflexible, not adaptable to multiple-factor situations where requirements constantly shift. This is, of course, always the case when the subjects under consideration are human beings.

In the years that followed, together with the counsel of Phil Erdberg, a great friend and a nationally prominent expert in tests and measures, I've written four books, each bringing the model forward, each with a subtitle containing the word "collaboration." Any complex clinical situation involving specialists of any sort requires useful communication and collaboration between all involved parties, patient and family included.

The move from a generic collaborative model to one centered around the integration of psychiatry and systemic medicine was natural. The interface between psychiatry and systemic medicine was a matter of personal interest and was a less popular topic at that time than it is now. So, that was the next

area to tackle. Fortuitously, I found Jim Bourgeois through his excellent *Casebook of Psychosomatic Medicine* (Bourgeois *et al.*, 2008). For the past several years we've worked hard, along with Phil Erdberg, to refine this model and incorporate it into this book.

This background should give you an idea about why and how this model of care has come about. It should not be difficult to see why we picture this work as a potential subspecialization within psychiatry and as an ideal area of practice for psychiatrists who have training in psychosomatic medicine, or dual training in psychiatry and family practice or internal medicine. It also is promising as an area of practice for primary care physicians (PCPs) who are interested in undertaking some additional training to expand the range of their practice to address the needs of "complex patients," and especially those with psychiatric co-morbidity. These are the patients with systemic medical, psychiatric, and psychosocial co-morbidity who populate, and, in ways, drain the medical system.

In effect, these are the patients nobody wants. Their initial encounter is generally with primary care providers. Multiple referrals are made to specialists. Most frequently they are referred back to PCPs who may have neither the time, patience, nor the psychiatric skills to handle their incessant and often emotionally based complaints. These difficulties are often expressed as somatoform disorders or as physical accompaniments to mood and anxiety disorders.

Our proposal is as follows: that the healthcare system explicitly re-embrace these patients, through the vehicle of multidisciplinary teams, each structured to the needs of a specific patient or group of patients. Models for psychiatric and conjoined psychiatric-systemic medical care of these challenging patients have needed to be developed to encompass the practical realities surrounding their care. The medical–psychiatric coordinating physician (MPCP) model is designed for this purpose.

Endorsements

"Today, organized medicine struggles with the disorganized havoc that complicated patients routinely wreak on the efficiency of systematized, evidence-based, protocolized, ultimately simplistic practice approaches. Models that embrace complexity are needed. In a book richly embroidered with extended case studies, a trio of clinicians with decades of diverse experience among them formulate an approach to what they call the "psychiatrically comorbid, management-intensive complex patient." This model rests on the herculean shoulders of their version of the "compleat" doctor, the "Medical–psychiatric coordinating physician" (MPCP), a master of the medical, psychological, and diplomatic skills the authors contend are necessary to wrestle not only difficult patients, but also their befuddled treatment teams into clinically responsive submission. This model insists upon teamwork, with the MPCP as both head coach and cheerleader. For those of us laboring to make sense of the clinical maelstroms within which we spin – too often in isolation – this book offers ideas and reassurance to help master the storm rather than founder in its vortex. It provides a cerebral roadmap for overwhelmed and desparate clinicians striving to blaze sensible trails through senseless systems of care."

J. Michael Bostwick, MD, Professor of Psychiatry, Mayo Clinic, USA

"With this book, these experienced clinicians propose a very innovative model of clinical Medical–psychiatric work with complex patients. The MPCP model identifies, structures, and integrates the key elements needed to comprehensively understand the diagnostic and therapeutic aspects pertinent to efficiently and collaboratively approach a patient's Medical–psychiatric condition. Not only do the authors present the model, they also guide the reader step by step through the implementation process, its essential phases and pitfalls risks.

Throughout, the authors are clear and straightforward in addressing the clinical issues that clinicians must consider when working with all patients, particularly complex ones. These include patient bias, professional bias and subjectivity, and systemic/inter-professional work bias. So, it's a book on how to best evaluate and treat patients with all the complexities related to diagnostic and treatment issues. It considers the patient's medical and social conditions, most contemporary scientific knowledge, and the medical care environment.

In this time of fragmentation in the care of complex patients and "algorithmic practice," the MPCP Model addresses conflicting issues and offers patient-centered solutions. It also integrates aspects of shared decision-making and shared mental health care approaches. Some readers may be tempted to stop reading after a few chapters, finding the MPCP model too idealistic. I would invite you to read the book cover to cover, to better comprehend the model's realistic approach to patients care, and discover many pearls of clinical wisdom.

I most appreciated the author's efforts to increase clinical judgment through many "truing tools" presented and illustrated with numerous medical and psychiatric case vignettes. The model aims to facilitate the process of confirmation or rejection of clinical hypothesis, and improve clinical accuracy. The MPCP model will probably be recognized as an advantageous clinical–scientific model based on critical thinking, and a model offering a methodology for experienced based clinical judgment (EBCJ)."

Fabien Gagnon MD, DPsy, CCFP, CSPQ, FRCPC, FCFP, DFAPA, DFCPA, FAPM
Co-founder of the Canadian Academy of Psychosomatic Medicine, Professor,
Head of the Division of Consultation-Liaison Psychiatry and Psychosomatic Medicine,
Department of Psychiatry and Neurosciences, Université Laval, Québec, Canada

"Patients' trust is crucial to the outcome of medical treatment. This trust is often violated when treating patients with multi-morbidity as their treatment is complicated by all kinds of interactions, including diagnostic and pharmacological, reduced coping, and inconsistencies and inadequacies in communication among healthcare professionals. These factors are often ignored, negatively affecting the trust of patients and the outcome and cost of treatment.

This book focuses on the analysis and management of complexity, forming an antidote to the over-valuation and current dominance of the fragmenting DSM-IV, DSM-V classification. Thinking about complexity unifies the treatment of multimorbid patients and should serve as a guide to multi-disciplinary teams who treat these patients. Complexity thinking should be an essential part of training of these professionals, as it provides a unifying language which could unify the divided field of professional organizations focusing on multi-morbid patients. The value of this book for the further development of professional treatment of multi-morbid patients cannot be overestimated."

Frits J. Huyse MD, Professor, Department of Internal Medicine,
University Medical Center Groningen, The Netherlands

"Doctors Frankel, Bourgeois, and Erdberg's detailed and honest book deliberately exposes an embarrassing secret - that medical care in our society is unnecessarily divided. With decades of clinical experience each, they quietly encourage a revolution in the way we practice medicine. Why accept the artificial schism between mind and body when integration of care is so intuitive and

effective? The "MPCP" model suggests that, rather than limiting ourselves by self-imposed boundaries, physicians, particularly psychiatrists, explore the full spectrum of a patient's mental and physical health, utilizing "truing" measures that enable us to judge our work by concrete results."

Debra Kahn, MD, Assistant Clinical Professor, Department of Psychiatry and Behavioral Sciences and Director, Psychosomatic Medicine Service, University of California at Davis, Sacramento, CA, USA

"This book proposes an innovative model for providing care for Medical–psychiatric complex patients, a rapidly growing population that require disproportionate attention and excessive resources for their care. According to this model, physicians, general psychiatrists, and physicians trained in both psychiatry and Internal/family medicine, lead multi-disciplinary teams and are accountable for efficiency and results. The physician-led "medical–psychiatric coordinating physician (MPCP)" model not only appears to improve treatment outcome, but also provides for containment of costs by reducing redundancy and curbing excess in the use of services. Other benefits include improved diagnostic accuracy and decision-making, as well as better communication among physicians and allied health professionals. This is a cutting-edge book, essential for medical educators, administrators, and providers."

Robert McCarron DO, Associate Professor, Department of Psychiatry and Behavioral Sciences, University of California at Davis, Sacramento, CA, USA

"Born from years of vigorous practice and conscientious reflection, this unique volume is a trusty trekking guide across clinical terrain that is both familiar and novel: familiar because the multi-dimensional challenges are recognized by every physician, yet novel because we are enabled to see old problems in fresh, invigorating relief. Do not let careful definitions or occasional new acronyms fool you: you are not holding an ivory tower treatise! This delightful work – suffused with rich, authentic clinical material (no idealized composite patients or mawkish bedside memoirs here) – grows on you. By the end, you have found a firm friend with whom you want to hike over and again. Rooted in high regard for the individual patient, tempered by real-life complexities, and unwilling to lose sight of evidence supported treatments, the authors generously give the Medical–psychiatric physician a strategy for transformative service that stimulates the mind and satisfies the soul."

Kemuel Philbrick, MD, Assistant Professor of Psychiatry, Mayo Clinic, USA

"This is a well-written guidebook for psychiatrists, primary care physicians, and students as they develop a way to consider and approach clinical work with complex cases. It has an engaging style using many well-timed case reports.

The authors articulate the need for coordination of care by a multidisciplinary physician team, bringing this topic of great current interest into focus by addressing the more difficult and complex patients with co-morbid medical and psychiatric conditions.

While the current movement towards team approaches applies to all patients, the complex patients addressed here are the ones that most require a care team. These prevalent patients represent the key problem every team effort must resolve because they are challenging, often refractory to current care, and have mental health problems. Implementing the patient centered, team-based approach outlined will enhance both care and safety for patients currently receiving uncoordinated care, responding to the concerns of the Institute of Medicine contending that modern medicine is derelict in patient-centered care and patient safety.

In addition, this book brings a very skilled and much needed psychiatric perspective to team care which can can guide non-mental health professionals in structuring their teams. Over two thirds of presently diagnosed (via epidemiological surveys) mental patients are never seen by mental health professionals, and are cared for entirely in primary care thirds by medical physicians who have had little training for this kind of work.

The professional and scholarly backgrounds of the authors are impeccable. This book will be germane and useful to ever-burgeoning numbers of providers, administrators, payors, and others interested in team-based care."

Robert Smith MD, Professor of Medicine and Psychiatry,
Michigan State University, East Lansing, MI, USA

"While clinics, research, teaching, and healthcare organization are still focused on specific diseases, physicians are increasingly confronted with complex patients suffering from multiple somatic and psychosocial morbidities. This book introduces a treatment model for diagnostically complex and management-intensive complex cases. The multiple interrelated dimensions of complexity – clinical, operational, diagnostic, and management complexity – and the rationale and clinical application of the proposed integrated treatment model are comprehensively described and discussed.

This very thoughtful book, written by clinicians for clinicians, will contribute to complex patients receiving better care, and help physicians to feel more at ease and better equipped to handle complex patients, a large patient population. This book should also be read by other healthcare professionals, such as researchers, teachers, or policy makers, who are motivated to help to deliver more adequate and efficient care to the complex medically ill."

Friedrich Stiefel, MD, Chief of Service, Psychiatric Liaison Service, University Hospital of Lausanne, Switzerland

"If you're searching for a smarter, more effective way to take care of the 10% of patients who command 70% of our healthcare costs, this book is for you. The "complex patient" with co-morbid medical and psychiatric conditions demands a new approach and a new role for the psychiatrist leading the clinical care team. Here's a richly detailed guide to tackling one of healthcare reform's high priorities."

Lawson Wulsin, MD, Professor of Psychiatry and Family Medicine, University of Cincinnati College of Medicine, Cincinnati, OH, USA

"Doctors Frankel, Bourgeois, and Erdberg propose an innovative model for providing individualized, comprehensive care for Medical–psychiatric complex patients–a group of "patients nobody wants." The MPCP model calls for psychiatrists to extend their duty as consultants to primary care providers, and become physician leaders who coordinate care among primary care providers, as well as, psychotherapists, social workers, and other medical and mental health specialists. This book uses case examples to illustrate the fact that, while some initial investment is needed to take care of the most complex Medical–psychiatric patients, in the long-run the investment pays off exponentially in terms of reduced, unnecessary medical work-ups, lower re-hospitalizations, and, most importantly, improved patient outcomes. The book is a must-read for medical educators, physical health and mental health policy makers, and physician leaders."

Glen Xiong, MD, Associate Clinical Professor, Department of Psychiatry and Behavioral Sciences, University of California at Davis, Sacramento, CA, USA

Acknowledgments

Life is full of miracles. Mine have been manifold and go by the names of Diane Engelman, my remarkable neuropsychologist wife; Peter and Cara, my incomparable adult children; Tracy, Hilary, and Iishwara, the equivalent in the step-children category; and Kaliani and Jaidev, who top the "neatest grandchildren" list. All of these dear people have fueled my enthusiasm for developing the treatment model we describe in this book; a model of care that we hope will be welcomed as a significant contribution to our field.

And, then, of course, there is the inspiration of innumerable colleagues. Prominently included is Roger Kathol, MD, leader in the field of "clinical complexity," and an author for the forewords for this book. Special thanks go to Joanna Chamberlin, our editor at Cambridge University Press and an ever-present source of light and wisdom during the creation of this book, and to Richard Marley, Publishing Director for life sciences and medicine at Cambridge University Press, who discovered and encouraged us from the beginning.

Steven A. Frankel, MD

I wish to thank my supportive family: my wife, Kathleen M. Ayers, PsyD; my son Emile; and daughter Gigi for their support and encouragement.

Dr. Bourgeois wishes to dedicate his part of this work to the many inspirational leaders in Psychosomatic Medicine who serve as examples and role models for the integration of medicine and psychiatry. Their vision is one of unified medical care, especially pertinent for patients with "clinical complexity." This group of physicians is represented and supported by The Academy of Psychosomatic Medicine. "The Academy" has been in the forefront of the development of integrated models of care such as the one we present in this book. I hope that this volume serves as a significant support to patients, physicians, and other health professionals as they carry out this work.

James A. Bourgeois, OD, MD

For Judy and Danny.

Philip Erdberg, PhD