“Integrated Care Moments” Shape Team Approach

Practitioner profile: Parinda Khatri, PhD

By the time psychologist Parinda Khatri, PhD, met with her, the teenager had made half a dozen trips to the emergency room complaining of chest pains. After a series of expensive medical work-ups revealed no problems, the girl came to see a pediatrician at Cherokee Health Systems in Knoxville, Tenn., who sent her for a quick consultation with Khatri. “It was unlikely that a 6-year-old girl was having a heart attack,” says Khatri, director of integrated care at Cherokee. A 5-minute assessment revealed the real problem: panic attacks that began after a date rape.

“We have epiphanies like that every day,” says Khatri. “We call them ‘integrated care moments’ — moments when we realize that we’re really able to make a difference in a person’s life because we’re bringing in medical, behavioral and other areas of expertise and working together as a team.”

Making a difference

When Khatri arrived at Cherokee as a part-timer in 2001, the organization was already well on its way toward the complete integration of psychological and physical health services. That shift began in the early 1980s when Cherokee — which started as a community mental health center — opened its first primary care clinic. Once Khatri was ready to come on board full-time a year later, Cherokee created the position of director of integrated care for her.

Today Khatri supervises psychologists and other “embedded behaviorists” in 15 primary care clinics across 11 counties. During a typical day, she handles a variety of professional activities that include providing clinical supervision, developing new clinical practices or programs, working on quality improvement initiatives and, of course, caring for patients.

Working as part of a team within the primary care area, Khatri and her fellow behaviorists tackle problems like depression and anxiety. They also help people stop smoking, manage their weight and make other lifestyle changes to improve their health. And they enable people to manage their illnesses, whether that means helping patients with diabetes stick with their treatment regimens or teaching those with asthma how to avoid situations that trigger attacks.

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As team members, says Khatri, psychologists contribute their clinical experience, knowledge of evidence-based interventions and critical thinking skills. But while psychologists bring much to the table, so do other health-care providers. “We all have something unique to add when it comes to improving the health and psychological wellness of our patients,” she says.

Plus, the team members are constantly helping each other. “The physicians, nurses and nurse practitioners are also behavioral health ‘extenders’ who help address behavioral health issues, just like we’re helping address physical health issues,” she says.

That high level of interdisciplinary collaboration isn’t the only way this work differs from traditional psychotherapy. The environment is fast-paced, and interventions are brief and focused. “Patients access us as they need to, just like they would a primary care provider,” she explains. “You don’t see your primary care provider every two weeks for 45 minutes.”

Integration allows behaviorists to identify problems and intervene even if patients have just come in for a flu shot or blood pressure check, says Khatri. By reducing the stigma associated with mental health care, she adds, that approach
helps to ensure that people get the treatment they need.

The care patients receive is also more convenient. Instead of waiting a few weeks to see a psychologist and having to go someplace else, for example, they have immediate access to a psychologist at Cherokee.

But convenience is only the beginning, emphasizes Khatri. “The care is better when all the different providers are talking with one another and collaborating,” she says. “We’re all supporting each other to improve the patient’s overall health status.”

The Cherokee approach also saves money. “What we find is that when a patient sees a behavioral health consultant, it actually reduces medical utilization,” says Khatri, who explains that psychosocial distress accounts for a huge proportion of medical visits.

When Cherokee compared medical utilization in the two years after a visit with a behavioral health consultant to utilization in the two years before, the health system found that seeing the consultant decreased medical utilization 37 percent for pediatric Medicaid patients, 27 percent for adult Medicaid patients and 20 percent for commercially insured patients. According to insurance claims data, the approach has also reduced emergency room use.

Those data are especially important given Cherokee’s role as a hybrid community mental health center/federally qualified health center that serves patients regardless of their ability to pay, says Khatri.

A growth opportunity

Data like Cherokee’s have helped convince an ever-growing number of primary care practices that they need a psychologist. “There’s a tremendous need,” says Khatri.

But not every psychologist can jump right into an integrated setting, she warns. Because decisions must be made very quickly, psychologists need significant clinical experience and knowledge of evidence-based practice. Psychologists in these settings should also have some familiarity with primary care medicine, such as what lab results may suggest or when a patient’s medication regimen may need to be altered.

Those are things any psychologist can learn, says Khatri. What’s even more important are the right personality and aptitude. Those who thrive in an integrated care setting are good communicators who are flexible, able to think on their feet and attracted to variety and high-energy environments.

Khatri’s own training — she received a clinical psychology doctorate from the University of North Carolina in 1996 — didn’t completely prepare her for this work. “I got really good training in traditional clinical psychology, but I had very limited contact with primary care or other health-care providers,” she says.

What was more helpful was a behavioral medicine postdoc at Duke University Medical Center. Working in a cardiac rehab program, Khatri learned a new way to work with patients. “I’d be walking with people on the track or [talking with them] while they were on the exercise bike,” she explains. “It wasn’t the traditional, private 45-minute psychotherapy session.” Khatri also had earlier stints as a consulting psychologist for an obstetrics/gynecology practice and a cardiology practice and as a clinical psychologist working as part of a pediatric cardiac and lung transplant team.

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Khatri now finds herself re-orienting students in the psychology internship program she directs at Cherokee. Often when people are more traditionally trained, they come to primary care and think they can use traditional mental health assessment and treatment strategies, says Khatri. Not so. For example, she notes, interns in primary care can’t take several sessions to establish a diagnosis.

“Our primary care providers are not going to wait,” she says. “They’re asking us, Why is this patient not taking his blood pressure medication? Why are her sugar levels out of control? What’s going on with this patient?”

The director of primary care also meets with trainees to provide an overview of primary care medicine, language and protocols.

“There’s so much cross-fertilization of knowledge,” says Khatri. “The primary care providers will learn things like behavioral intervention and deep breathing exercises from us, and we’ll learn about Coumadin management and TSH levels from them,” she says. “That’s really exciting as a health-care professional — to teach something and learn something every day.”