INNOVATIONS IN PRIMARY CARE

Neuropsychologist Consultations in a Primary Care Setting

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THE INNOVATION

Identifying cognitive impairment can be challenging for primary care clinicians. Neuropsychologists have expertise in assessment, diagnosis, and interventions targeting cognitive impairment. We introduced a neuropsychologist into primary care to improve the identification of cognitive dysfunction via consultation and brief cognitive evaluations.

WHO & WHERE

One neuropsychologist from our large northeast Veterans Affairs (VA) medical center was co-located in primary care one afternoon per week for brief cognitive evaluations, including written and verbal feedback and recommendations, for veterans aged over 50 years. The neuropsychologist was available for phone or secure e-mail consultation with primary care clinicians throughout the workweek.

HOW

Stakeholder interviews with patients and primary care and mental health leadership confirmed the need for improved access to cognitive evaluations and preference from patients to complete these in primary care settings. A multidisciplinary Primary Care Behavioral Health (PCBH) team already existed within the VA medical center; this team functioned as a liaison between primary care clinicians and the neuropsychologist, offering consultation on integrating into the primary care system, championing the potential benefit of this clinical service, and providing education and prompting to clinic staff regarding patients who might benefit from evaluation.

The service was introduced at a primary care staff meeting that included clinicians and clinic management. Staff were provided with information detailing the role and availability of the neuropsychologist, a description of appropriate referrals, and contact information. The neuropsychologist was co-located in primary care and had the opportunity to interact with clinic staff, communicate availability of this service, answer general questions about appropriate referrals, and provide consultation on specific patients.

Patients were typically referred directly from their primary care clinician, although a small number of referrals came from PCBH consultants. Concerns about cognition were identified by the patient, patient's family, or primary care/PCBH clinician. The clinician contacted the neuropsychologist directly via a note in the electronic medical record or secure e-mail. Despite the availability for "warm-handoffs," there were barriers to clinicians using this service in real time, including the limited availability of the neuropsychologist in primary care and patient preference to return on a different day. Most patients were seen for assessment during a separate appointment on a different day. There were a small number of patients for whom alternative care plans, including longer outpatient neuropsychological evaluation, referral to neurology, or coordinating evaluation in another clinic (eg, geriatric medicine), were identified by the neuropsychologist.

Patients referred for brief cognitive assessment presented with varying levels of cognitive impairment, ranging from independent functioning to dementia, and high rates of co-occurring psychiatric symptoms (eg, depression, anxiety, post-traumatic stress disorder [PTSD]). Referrals aimed to clarify the existence of a neurocognitive disorder separate from other contributing factors such as psychiatric symptoms, psychosocial stress, and pain.

LEARNING

Translation of this service into other settings may be optimized if neuropsychologists: (1) tailor evaluations to meet the needs of primary care patients and clinicians, including brief evaluations with rapid feedback and recommendations, and (2) collaborate with existing behavioral health clinicians in primary care to enhance primary care clinician awareness of the availability of brief cognitive evaluations. This care model has improved patient access to cognitive evaluations, reduced wait times, and allowed patients to centralize care in primary care. Additionally, it has provided primary care clinicians with a resource for rapid consultation, targeted assessment, and prompt feedback, in turn reducing the burden on clinicians to independently manage patients with potential cognitive impairment.

For supplemental information, including author affiliations, key words, and references, see https://www.AnnFamMed.org/content/18/4/375/suppl/DC1.

Conflicts of interest: authors report none.

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