American Psychiatric Association

Ad Hoc Work Group Report on the Integration of Psychiatry and Primary Care

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EXECUTIVE SUMMARY

APA BOT Ad Hoc Work Group on the Integration of Psychiatry and Primary Care
(APA Assembly and BOT version)

Background:
In May 2008, The APA Assembly endorsed the Enhancing Primary Care/Psychiatric Medicine Collaboration/Integration Action Paper¹ and referred it to the APA Joint Reference Committee for implementation via the Council on Psychosomatic Medicine. In October 2008, the Joint Reference Committee, after having reviewed the Council's recommendations, referred the revised Action paper to the APA Board of Trustees (BOT) for expedited review. In December 2008, the BOT, through President Dr. Nada Stotland, appointed an Ad Hoc Work Group, with the charter to develop an action plan/white paper focusing on systems/services and policy regarding the integration of psychiatry into primary care, with a special emphasis on items 3, 4 and 6 of the principles outlined in the report of the Ad Hoc Work Group on Systems of Care chaired by Dr. Steven Sharfstein, as presented to the Board of Trustees in October 2008.² Items 3, 4 and 6 of the Systems of Care Report are:

3. Timely access to psychiatric care and continuity of care are the cornerstones for quality, even as a continuum of medical and non-medical services becomes available that would encourage maximum independence and quality of life for psychiatric patients.

4. There must be full parity of psychiatric treatment with the rest of medicine and utilization management must be the same for people with mental illness as well as for other medical illnesses. Payment and utilization should be on the basis of treatment and services and not on diagnosis.

6. Access to psychiatric care should be provided in numerous settings, including private offices, community mental health centers, specialty clinics, and hospitals as well as in the workplace, schools, and correctional facilities. Psychiatric care should be fully integrated with the rest of medicine in primary care settings and in hospitals.

An interim report of the Ad Hoc Work Group was presented to the BOT at its March 2009 meeting. The principle of the document was approved and the BOT gave the mandate to finalize a position paper with accompanying supportive documents (white paper) by the May 2009 annual meeting. Dr. Roger Kathol chairs the APA Ad Hoc Work Group on the Integration of Psychiatry into Primary Care. Its members include Drs. Wayne Katon, Lauren Sitzer, Eliot Sorel, and Anita Everett. The BOT added Drs. Jay Scully, Jack McIntyre, and Mary Helen Davis to the Work Group in March. APA personnel working on the report are Irvin L. “Sam” Muszynski, J.D., and Mary Ward, with participation by Eugene Cassel and staff of APA’s Department of Government Relations and Office of Communications and Public Affairs.

Rationale (A Problem with a Solution):
• Untreated and inappropriately treated mental illnesses represent a significant public health problem
• Many individuals with mental conditions do not seek treatment in specialty mental health settings
• Seventy percent of patients with mental illnesses receive no treatment or ineffective treatment for their psychiatric conditions, in part because the majority of their care is provided in non-mental health settings
• Mental Illnesses increase the morbidity and cost of medical treatment
• Integrated and collaborative clinical care models have demonstrated effectiveness in improving the outcomes for persons with mental illness seen in primary care
• The best outcomes in integrated care have been shown to occur in models that include either ongoing evaluation and follow-up visits with a psychiatrist or a psychiatrist providing caseload supervision and decision support to case managers
• Current healthcare financing systems are a primary barrier to the adoption and implementation of these effective clinical modes

**APA Health Reform Strategy:**
The Ad Hoc Work Group on the Integration of Psychiatry and Primary Care suggests that APA strategy for health care reform should be driven by the following positions:

### APA Health Reform Position

On December 23, 2008, the President of the United States signed the Mental Health Parity and Addiction Parity Act of 2008 into law, a move that requires that mental health and substance abuse treatments be covered on par with any other health care. In order to provide accessible, affordable and quality health care to all Americans, evidence-based psychiatric treatment must be available in both the primary care and specialty medical settings (i.e., by psychiatrists and other mental health professionals). In order to facilitate this outcome, the American Psychiatric Association (APA) makes the following recommendations:

**Clinical Reform:**
- Psychiatric care should become an integral part of the “team” approach to health improvement in general medical settings. This approach can result in lower outpatient and inpatient medical costs.
  - *Outpatient Models:* Research shows that a collaborative team approach, which includes primary care case managers and their supervision by a psychiatrist in general medical settings and psychiatric consultation and treatment for patients who do not get better, improves clinical and cost outcomes in general medical patients with anxiety and depression with and without co-existing psychiatric and medical conditions, such as diabetes and depression. The APA recommends support for such programs for all persons suffering from mental illness and substance use disorders in general medical settings.
  - *Inpatient Models:* The APA urges support for the development of programs that allow concurrent general medical and mental health intervention for high-cost and complex patients with co-existing general medical and mental health problems in general hospitals. These should include delirium prevention programs, proactive psychiatric team consultation services, and complexity intervention units.

**Fiscal Reform:**
- The fulfillment of medical parity, meaning that psychiatric and other mental health services and reimbursement are comparable to general medical health and paid through general medical benefits. This can be achieved through the phased consolidation of general medical and mental health budgets. (It should be noted that without this fiscal component, the clinical reform outlined above would not be deliverable.)
  - Fulfillment of parity legislation dictates that payment for psychiatric and other mental health services and for psychiatric facilities be consolidated with general medical health,
transitioning into one “health” budget.

- Mental health professionals and facilities should become a part of general medical networks and the health facility infrastructure, paid on par with other practitioners and facilities from one funding pool.
- The APA recommends reimbursement procedures for clinical programs, including clinical services sustaining payment for billed codes, that encourage high-quality mental health care and, most importantly, for services directed at enhanced outcomes using evidenced-based methods as an essential part of fiscal health reform.

**The Value Proposition:**
Fifty percent of patients with mental health problems are treated only in the general medical sector, and many more receive ineffective treatment without access to outcome-changing psychiatric intervention. This leads to documented lack of response to general medical treatment, disability, and the unnecessary use of additional health care services, collectively estimated to cost as much as $300 billion annually. The APA urges the integration of general medical and evidence-based psychiatric care, organized with general medical teams (outpatient) and concurrent care on general medical inpatient services in general health care settings. This process has already demonstrated 1) improved quality of care and clinical outcomes, 2) reduced social and vocational impairment, and 3) a long-term reduction in total health care costs. The way to ensure such outcomes is for health reform initiatives to make psychiatric service support a part of general medical benefits and outcome-changing psychiatric treatment a core part of care in the general medical setting.

**Specific Recommendations Following from the APA Health Reform Position:**

**Immediate**

1. Develop an education campaign for APA leadership and general membership about the value of integrated care. (Emphasize that this will enhance and expand practice opportunities for psychiatrists in the future and reduce reimbursement hassles regardless of practice location. The changes recommended in this white paper should not change support for existing psychiatric practice activities.)

2. Meet with the leadership of psychiatry and other primary and specialty medical care disciplines individually and through organizations, such as the AMA, American Osteopathic Association, the American College of Physicians, and American Academy of Family Physicians to explore strategies for reducing barriers to the adoption and implementation of integrated and collaborative care. Meetings should also be included with subspecialty psychiatric groups to explore their collaborative work, such as that done by the American Academy of Child and Adolescent Psychiatry with the American Academy of Pediatrics. Consideration should be given to putting on an interdisciplinary “summit” on the integration of psychiatry into medical settings.

3. Survey APA Councils for recommendations regarding barriers to and strategies for the implementation of integrated and collaborative care within their areas of expertise.

4. Involve the APA Assembly of District Branches in developing recommendations and implementation strategies.
5. Develop a strategy to promote integrated and collaborative care to corporate healthcare purchasers, government programs, and medical health plans.

6. Communicate with the World Health Organization to identify opportunities to support initiatives that support the WHO, “No Health Without Mental Health” campaign.

7. Develop recommendations on strategies to complete the intent of legislation on parity for mental and general medical health care, i.e. by making mental health and substance use disorder care a part of total (general medical and mental) health benefits.

8. Meet with the APA Government Relations staff to develop state advocacy strategies that will identify potential opportunities to support the implementation of integrated care through state government and state insurance regulations.

Mid and Longer Term

1. Meet with Federal and State policy makers to propose official recognition of the public health significance of untreated mental illness and the importance of collaborative care in changing this.

2. Meet with APA Healthcare Systems and Financing, Government Relations, and Communications staff to develop an advocacy strategy that will identify potential opportunities to support the implementation of integrated care in federal healthcare programs. Include consideration of federal parity laws and related regulations.

3. Develop a toolkit that will provide practice implementation strategies for psychiatrists and primary care physicians who want to implement integrated care.

4. Review current CPT coding for opportunities to support care coordination and integrated care.

5. Develop templates and timelines for transitioning mental health and substance use disorder care to general medical CPT coding practices.

6. Review current residency training requirements toward ensuring that all psychiatry residents are exposed to training in integrated care, including the supervision of mental health teams.

7. AAMC and residency directors in collaboration with APA Office of Education should develop psychiatric educational programs about the assessment and treatment of patients with acute and chronic comorbid medical illness and mental health/substance use disorders for medical students, psychiatric and non-psychiatric residents, and other health professionals as a part of collocated and integrated inpatient and outpatient clinical settings.

8. Initiate demonstration projects on collaborative care through academic institutions, medical home initiatives, community mental health centers, and community health centers.


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Introduction:

Poor access to psychiatric care for patients with mental health and substance use disorders (MH/SUDs, also known as “psychiatric” disorders) is a significant public health problem in the US. Similar to other medical conditions, most mental illnesses are treatable, yet fewer than twenty percent of those with MH/SUDs receive minimally effective treatment. In fact, most patients with MH/SUDs, 50% of whom are primarily seen only in the primary care setting, receive no treatment at all. Untreated MH/SUDs cause an
extreme burden on our society in terms of high general medical service use and health care costs, lowered workplace productivity, and disruption of family and social roles.\textsuperscript{4}

The current design of our general medical and mental health care systems does not support the integration of care that clearly demonstrates improved quality and outcomes, particularly in the general medical setting. Psychiatric disorders are medical conditions, largely excluded from treatment in the “physical” health setting, as if they were not a part of health and integrally connected to co-existing general medical conditions. Complex biological processes interact with the psychosocial dimensions of illness in both psychiatric and other medical conditions to form a biopsychosocial template. Yet our language remains dualistic, separating “mental” from “physical”.

Challenges remain as to how to communicate clearly that the mind and body are inseparable parts of the same organism. They interact with each other.\textsuperscript{5} We can better help our patients by identifying connections between, and comorbidities among, the psychiatric and medical symptoms with which they present; and by integrating the delivery of psychiatry and primary care services. By doing so, we will enhance quality, access, and outcomes and will achieve parity and nondiscrimination.

This white paper provides a referenced framework for the American Psychiatric Association’s (APA’s) policy as psychiatry takes on an increasing role in providing MH/SUD care in the primary care setting. It is intended to equip the APA’s membership with information that will enable strong advocacy for involvement in the diagnosis and treatment of psychiatric conditions regardless of the patient's service location. This will increase our professional capacity to provide high quality care in the settings preferred by patients. By doing so, it is possible to improve quality of care, reduce medical illness morbidity and mortality, attenuate personal impairment, and with lower overall costs. This document is divided into three sections: 1) defining the problem; 2) the solution, integrated care; and 3) recommendations.

**Defining the Problem**

*Mental Health Conditions Are a Significant Public Health Problem*

The burden of MH/SUDs on our society is substantial.\textsuperscript{6} They are common and are disabling.\textsuperscript{7} The adverse impact of untreated MH/SUDs extends to individuals, families and communities.\textsuperscript{8} Untreated, they result in direct and indirect costs to our society. Direct costs include the increased total healthcare costs associated with the effect of untreated or ineffectively treated MH/SUDs on general medical illness treatment resistance and amplification of somatic symptoms.\textsuperscript{9} Indirect costs include persistent impairment at work; at school; and/or in other personal, social and family roles.

Anxiety and depressive disorders are associated with as much functional impairment as chronic medical disorders such as diabetes, heart disease, and COPD.\textsuperscript{10} Moreover, when these disorders are comorbid with general medical disorders, there is additive functional impairment.\textsuperscript{10} Depression has been shown in multiple studies in aging populations to be
associated with progressive decline in physical functioning. Effective treatments are available yet most individuals with mental conditions do not receive treatment.

**Individuals with Mental Conditions Often Do Not Seek Specialty Care**

There is a mismatch between the location of psychiatrists and of psychiatric patients (Figure 1). Only about two fifths of individuals with “serious” psychological distress receive care from specialty mental health clinicians. If all those with MH/SUD need, i.e. serious and less serious are considered, referral from the non-psychiatric setting occurs in less than half. Of those referred, less than half actually show up for their first appointment and as low as one in twenty follow up for a full course of treatment.

Individuals with MH/SUDs report that barriers to mental health treatment include cost, stigma and lack of knowledge about where to go for treatment. Even for those with insurance, cost is a significant barrier to seeking care from a psychiatrist. This has been referred to as underinsured. (There is hope that the recent passage of federal parity for Medicare together with existing and emerging parity laws in states will help to remedy disparate insurance coverage.)

Currently, much of the potential utilization and costs related to accessing specialty mental health services are controlled by financial disincentives created by the independently managed behavioral health reimbursement system. It is not unusual for persons with psychological distress, however, to be seen in primary care offices. Lowering utilization of mental health care is likely to increase utilization of primary care. In fact, patients with anxiety and depression utilize about twice as many visits to primary care physicians as patients without psychiatric disorders at twice the cost.

**Figure 1. Psychiatrist-Psychiatric Patient Mismatch**

Psychosomatic Medicine specialists offer a clinical, educational, and research bridge between medicine and psychiatry but are very limited in number, work primarily in hospital settings, and have significant reimbursement problems in supporting the type of work that
they do. Short supply of these specialized professionals correlates closely with the inability of primary care physicians to access psychiatric services for their patients.\textsuperscript{25}

*Individuals with Mental Conditions Are Seen in Primary Care*

Approximately one in five patients in primary care meets DSM-IV criteria for a psychiatric disorder and up to one-half of visits to primary care doctors are for stress related symptoms,\textsuperscript{26} such as poor sleep, fatigue, or headache.\textsuperscript{27} Both stressful life events and psychiatric disorders are associated with higher utilization of primary care and multiple minor general medical symptoms.\textsuperscript{28}

The higher medical utilization of patients with psychiatric illness for somatic complaints leads to higher medical costs. For instance, patients with major depression, anxiety disorders, and substance use disorders have been shown in multiple studies to have 50\% to 100\% higher total medical costs over a one-year period after controlling for sociodemographic factors and chronic medical illness (Figure 2).\textsuperscript{29-31} These increased costs occur in every component of utilization including emergency room, primary care visits, medical specialty visits, pharmacy, inpatient medical days, lab and x-ray, and mental health costs. Approximately 80\% of patients with anxiety and depression present initially with somatic complaints and often receive costly medical testing before the primary care physician recognizes the symptoms are due to these psychiatric disorders.\textsuperscript{32}

![Figure 2. Claims Expenditures for 6,500 Medicaid Patients With and Without MH/SUD Service Use](image)

The problem is considerably more prominent in patients with chronic and/or complex illness. In patients with medical and psychiatric multimorbidity, additional health care service use, which shows up mainly in the form of medical claims, can be two to three times that seen in patients without concurrent mental health disorders (Table 1). In addition to persistent patient suffering, untreated mental disorders in just the subset of medical patients with chronic illness are projected by Milliman, Inc., an international actuarial consulting firm, to cost commercial and Medicare purchasers alone between
$130 billion and $350 billion annually in additional health related, mostly general medical, expenses (Table 2). Enhanced quality of mental health treatment could potentially save medical costs in this population of patients with chronic medical illness and comorbid psychiatric conditions.

Table 1. Contribution of MH/SUDs to Added Cost in 100,000 Patients with Chronic Medical Conditions

<table>
<thead>
<tr>
<th></th>
<th>Annual Cost of Care without MH/SUD</th>
<th>Illness %</th>
<th>% Comorbid Prevalence MH/SUD</th>
<th>% Cost Increase in those with MH/SUD</th>
<th>Annual Added Cost in those with MH/SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>$5,220</td>
<td>6.6%</td>
<td>36%</td>
<td>94%</td>
<td>$11.7M</td>
</tr>
<tr>
<td>Asthma</td>
<td>$3,730</td>
<td>5.9%</td>
<td>35%</td>
<td>169%</td>
<td>$13.0M</td>
</tr>
<tr>
<td>Cancer</td>
<td>$11,650</td>
<td>4.3%</td>
<td>37%</td>
<td>62%</td>
<td>$11.5M</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$5,480</td>
<td>8.9%</td>
<td>30%</td>
<td>124%</td>
<td>$18.1M</td>
</tr>
<tr>
<td>CHP</td>
<td>$9,770</td>
<td>1.3%</td>
<td>40%</td>
<td>76%</td>
<td>$3.9M</td>
</tr>
<tr>
<td>Migraine</td>
<td>$4,340</td>
<td>8.2%</td>
<td>43%</td>
<td>149%</td>
<td>$22.9M</td>
</tr>
<tr>
<td>COPD</td>
<td>$3,940</td>
<td>8.2%</td>
<td>35%</td>
<td>186%</td>
<td>$22.9M</td>
</tr>
</tbody>
</table>

Unfortunately, less than 15% of individuals, who receive treatment for their mental disorder from their primary care or specialty medical physicians in the medical setting, are given “minimally effective” treatment. The result of this less than optimal circumstance is that patients with comorbid psychiatric and medical illness are non-adherent to medical therapy for chronic medical conditions (Table 3, Figure 3). 40-41 develop illness complications (Table 4), 40, 41 become disabled (Table 5), 42 die at an earlier age (Figure 4), and use substantially more health services (Figure 5), 43 the majority of which are provided in the general medical sector. High service use and cost persist over time unless patients show improvement of their psychiatric symptoms (Figure 6). 43

Table 3. Depression: Impact on Self-Management of Chronic Medical Illness

- Depressed patients with MI are more likely to drop out of exercise programs
- Smokers with history of depression are 40% less likely to succeed in quitting smoking over a 9-year period compared to non-depressed smokers
- Patients with major depression and coronary artery disease are less likely to adhere to low-dose aspirin therapy than non-depressed controls

Table 4. Depression: Effect on Risk of Diabetic Complications

- Incidence of coronary artery disease was 3 times as common over a 10-year period in diabetics who were initially depressed vs nondepressed.
- In a prospective study of children with type 1 diabetes, the risk of development of retinopathy was associated with duration of diabetes, time spent in poor glucose control, and time spent in major depression.

Table 5. Annual Work Days Lost and Disability Days for Depression and Diabetes

<table>
<thead>
<tr>
<th></th>
<th>Neither</th>
<th>Diabetes</th>
<th>Depression</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work Days Lost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Otolg Pato</td>
<td>4.5</td>
<td>6.3</td>
<td>13.2</td>
<td>13.1</td>
</tr>
<tr>
<td><strong>Disability Days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>2.2</td>
<td>3.6</td>
<td>7.9</td>
<td>23.4</td>
</tr>
<tr>
<td>Unemployed</td>
<td>6.3</td>
<td>8.9</td>
<td>23.2</td>
<td>43.8</td>
</tr>
</tbody>
</table>


Figure 4. Survival Outcomes as a Function of Depression

Figure 5. Annual Claims for 250,000 Adults With and Without MH/SUD Service Use

% of population: General Medical (GM) Service Use: 74.9%
MH/SUD Service Use: 10.0%
No Service Use: 15.1%

Figure 6. Effect of Improved Health on Total Health Care Cost in Year 2 for Patients with Documented Dual Diagnoses in Preceding Year

Katon et al., JGIM 20; 160-167, 2005
Barriers to the Integration of Psychiatry into Medical Settings

There are two major barriers that prevent or limit the incorporation of psychiatry into medical settings: health professional issues and payment issues.

Health Professionals as a Barrier to Integration

Health professionals, both from the primary and specialty medical care and the mental health sectors, create barriers to integration. They have practiced in separate settings for so long that many can no longer visualize what it would be like to address the entirety of health needs for common individuals in a single setting. They are used to independent practice, geographically separate clinical locations, segregated record systems, and limited communication. Many, in fact, don’t see a problem with disciplinary independence since they have never entertained the notion that mental health conditions may influence general medical health outcomes and vice versa.

While administrative changes may seem like the most important components contributing to challenges in the development of integrated programs, they are dwarfed by “cultural factors.” Over the years both physical and mental health specialists have built biases, e.g. “I don’t want mentally ill patients in my primary care clinic.” or “Primary care physicians don’t know how to talk with their patients.” and resentments, e.g. “Why don’t mental health personnel have to answer consultations as quickly as we do?” or “Why do mental health services always have to use “left over” space?” that have become magnified in health settings in which non-communication is the standard. Thus, both general medical and mental health professionals will need to adopt an attitude of collaboration and compromise as they jointly create clinical worlds in which psychiatric care becomes a part of general medical health. “Culture” change will require the development of a respect for cross-disciplinary qualifications and activities, diagnostic and therapeutic contributions, the coordination of work processes, the creation of a consolidated patient record, among many others.

Challenges for Primary Care Physicians

In the current segregated system, primary and specialty medicine care physicians recognize a need for mental health services in their patients but are not financially accountable for it since it is covered under behavioral health benefits. With integrated care, this changes since, to the extent that mental health factors contribute to persistent medical symptoms, they become responsible or assuring that the mental health factors contributing to general medical health outcomes are reversed. As a result, they will not only need to “make room” in their inpatient and outpatient setting for professionals who can make a mental health difference but also to organize them to facilitate efficient and effective reversal of total health disturbances. It will require handing off some organizational responsibility and space to mental health professionals but with the expectation that the ultimate outcome will take the form of improved total health for the patients served in their clinics and/or general hospitals.
Challenges for Psychiatric Physicians

In the current health environment, few psychiatrists provide clinical services in inpatient or outpatient general medical settings. This will mean that many will need to be trained in the care of medically ill patients with psychiatric comorbidity. Not only will they need to bolster their comfort with clinical service delivery in the medical sector, they will need to learn to work with and supervise other mental health professionals who will, as a part of “mental health teams,” collaborate in supplying psychiatric care to the large number of primary care and specialty medical patients suddenly entering the psychiatrist’s sphere of responsibility. Psychiatrists will need to work effectively with and supervise nurses, social workers, psychologists and other therapists as they service both the clinical needs of patients and the educational and support needs of referring physicians.

In addition to strengthening their clinical and supervisory functions, the new world of integrated service delivery will require that psychiatrists learn about and understand how to put together models of integrated care that bring value to patients (Table 6). For instance, in the outpatient primary care clinic setting, it is clear that standard scheduling of psychiatric patients for 20 to 50 minute appointments does not work since timely access to psychiatric services is a major factor. Rather, proactive case finding, such as with INTERMED technology, team approaches to care; and flexible mental health personnel schedules are preferred. In the inpatient setting, existing models suggest that proactive case finding and mental health team involvement brings the greatest value. These “consultative” services can be further augmented through the creation of complexity intervention units, which have full general medical and mental health assessment and treatment capabilities, in the general medical setting.

Table 6. Value-Added Clinical Programs

<table>
<thead>
<tr>
<th>• Proactive Psychiatric Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactive case finding—prevalence-based using measured complexity as entry point (INTERMED-Complexity Assessment Grid)</td>
</tr>
<tr>
<td>MH/SUD team size and constituency determined by population served</td>
</tr>
<tr>
<td>Early intervention with active follow-up</td>
</tr>
<tr>
<td>• Complexity Intervention (Medical Psychiatry) Units</td>
</tr>
<tr>
<td>High physical health and MH/SUD acuity capabilities</td>
</tr>
<tr>
<td>Co-attending model</td>
</tr>
<tr>
<td>Cross-disciplinary trained staff</td>
</tr>
<tr>
<td>• Integrated outpatient clinic</td>
</tr>
<tr>
<td>Collaborative (stepped) care—PH and MH/SUD professional co-location, same day billing</td>
</tr>
<tr>
<td>Active PH and MH/SUD collaboration with eye on interactive components</td>
</tr>
<tr>
<td>Common PH and MH/SUD electronic medical record</td>
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<tr>
<td>Use of care managers which address both physical and MH/SUD issues</td>
</tr>
<tr>
<td>• Unexplained physical complaints—“reframing” training for PCPs</td>
</tr>
<tr>
<td>• Substance Use Disorders</td>
</tr>
<tr>
<td>Brief intervention for alcohol abuse in PCP clinics</td>
</tr>
<tr>
<td>Use of medications for prevention of substance abuse in medical settings, e.g. buprenorphine, naltrexone</td>
</tr>
<tr>
<td>• Delirium prevention and intervention programs</td>
</tr>
<tr>
<td>• Other</td>
</tr>
</tbody>
</table>

Adapted from Kathol et al, Psychosomatics, 50:93-107, 2009

Payment as a Barrier to Integrated Care

Since the introduction of managed behavioral health in the early 1980s, access to psychiatric care in the clinical locations where the majority of those with mental disorders are seen, i.e. primary care settings, has been severely and persistently curtailed. Managed
behavioral healthcare organizations were created initially to manage psychiatric inpatient treatment costs but evolved to include management of all levels of behavioral health claims, excluding only pharmacy benefit management.

Psychiatrist practice patterns will not change unless reimbursement business practices change. Currently, carved-out (a MBHO owns and pays for behavioral health services and a medical managed care company [MCO] owns and pays for general medical health services) and carved-in (a MCO owns and pays for both general medical and mental health services but uses internal claims adjudication processes that separate the two as if they were carved-out) reimbursement practices create segregation of psychiatric care from all other forms of medical services for common patients (Table 7). Importantly, psychiatry is the only allopathic medical discipline in which this occurs, the core of the problem.

Table 7. Independent to Integrated Medical and Psychiatric Benefits

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>same</td>
<td>single identifier</td>
</tr>
<tr>
<td>Payment Pool</td>
<td>separate</td>
<td>single bucket</td>
</tr>
<tr>
<td>Network Providers</td>
<td>separate</td>
<td>all in one #</td>
</tr>
<tr>
<td>Member and Provider Support</td>
<td>separate</td>
<td>one call-in #</td>
</tr>
<tr>
<td>Approval Process</td>
<td>separate</td>
<td>uniform</td>
</tr>
<tr>
<td>Information Systems</td>
<td>separate</td>
<td>unified</td>
</tr>
<tr>
<td>Health Management Support</td>
<td>separate</td>
<td>cross-disciplinary</td>
</tr>
<tr>
<td>Coding and Billing</td>
<td>separate</td>
<td>consistent process</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>separate</td>
<td>single server</td>
</tr>
<tr>
<td>Data Warehousing &amp; Actuarial Analysis</td>
<td>separate</td>
<td>consolidated</td>
</tr>
<tr>
<td>Interaction of Systems</td>
<td>none</td>
<td>uniform</td>
</tr>
</tbody>
</table>

Independent management of MH/SUDs claims results in tremendous disincentives to provide mental health treatment in non-mental health specialty settings. In order to improve access to and continuity of psychiatric with general medical care in an environment of parity for healthcare, it will be necessary to consolidate independent mental health budgets into general medical health budgets and to reimburse psychiatric services as a part of general medical benefits. By doing so, it will be possible to co-locate general medical and psychiatric care regardless of clinical setting and to initiate efficacy-based models of care collaboration between psychiatrists and their non-psychiatrist physician colleagues. Payment systems that segregate mental health services from other health services perpetuate fragmentation, stigmatization and in some circumstances, where the management of mental health services is more restrictive than the management of health services, may constitute discrimination and lack of parity.

Some feel that by remaining under a separate budget and financing it is possible to preserve the limited funding that psychiatry receives. Analysis of how mental health and chemical dependence have fared over the years belies this assumption (Figure 7). Psychiatry’s share of the total health care dollar decreased from 6.3% to 5.1% between 1986 and 2003. The drop was even greater for the clinical services component of the budget (5.4% to 3.3%). In fact, psychiatry has lost at least four times greater value in the
health care dollar spend for mental health services than the medical sector has for medical services (Table 8). This occurred using a system of reimbursement in which money saved in mental health costs likely shifted to increased medical service use with a net total increase in health care cost (Table 9).

Currently psychiatric programs in the medical setting are often not fiscally sustainable once start up and special grant funds end. This is true for many integrated programs,
including Group Health in Seattle, Intermountain in Utah, and Kaiser in Northern California. The extent to which the recently enacted federal parity law will impact our currently segregated payment systems for mental health versus somatic health services is not known. In principle, the federal parity law requires that benefit management practices must be the same for general and mental health services. Insurers that unevenly restrict access to mental health services through higher copays or restrictive service utilization policies will be in violation of this law. Parity, however, does not encourage consolidation of the general medical and mental health budgets, paying for mental health service use as a part of general medical health benefits, and thus provides no specific incentive to facilitate the adoption of integrated care.

An additional fiscal consideration involves CPT coding that enables the accurate capture of physician effort during a service encounter. At this time, psychiatrists are often required to use psychiatric codes, i.e. 90801 through 90899. Health plans do not uniformly reimburse psychiatrists who use the physician billing codes commonly used in other medical specialties, i.e. the Evaluation and Management (E and M) codes. E and M codes are designed for clinical care encounters and are created to enable the capture of complexity of a service provided. The E and M codes, as well as psychiatric codes, are fee for service, encounter-based codes. They provide no support for the time involved to provide coordination of care with other professionals, outreach to patients outside of appointments, and clinical supervision of other allied professionals. These components of care have been some of the most important predictors of outcome and quality in evidence-based collaborative care models and will thus require financial support mechanisms for the future.  

The medical home model is currently being promoted as a mechanism for patients that would support better coordination of care through a primary care physician. It is ultimately designed to produce better outcomes for patients. Proposed funding for the medical home includes three mechanisms: 1) traditional fee for service would be billed for actual patient encounters, 2) a case rate would support care coordination activities, and 3) a performance-based addition would incentivize high performance care and adherence to care guidelines.

At present, little thought has been given to how mental health and substance use disorder care, including psychiatric care, would be integrated into the medical home. All of the financial barriers to psychiatric service delivery in the medical setting, listed above, remain and little has been done to include mental health issues into care coordination activities. Addressing both of these issues during formulation the medical home structure and reimbursement would be important to control the annual $300 billion in extra service use by medical patients who have untreated and concurrent mental health disorders.  

**Summary of Problem**

Mental conditions currently pose a tremendous burden to our national public health. Many individuals with mental conditions are seen and prefer to be seen in primary and specialty medical care settings where psychiatrists typically are not available. Psychiatrists are
physicians with specialized skills in the diagnosis and treatment of individuals with mental conditions. Given the current opportunities that may be associated with healthcare reform, now is the time for American psychiatrists to consider how our profession can best serve the greatest number of individuals in the most effective and efficient way. Now is the time to develop a clear pathway that leads to the integration of psychiatrists and psychiatric services into medical settings, including the medical home.

**The Solution: Integrated Care**

*Definition—Integrated Care*

Integrated care is a term we have used in this project to describe the provision of mental health services in primary care and other medical settings wherein all professionals are engaged with the improvement of both general medical and mental health outcomes for patients. Some models of integrated care include psychiatrist-led mental health teams that are integrated into a primary care setting. The term *integrated care* has also been applied to the staffing arrangement of psychologists and/or master level therapists working with prescribing primary care physicians in primary care settings. Integration includes sharing common office space, staff, medical records, office supplies and billing services with primary care specialty medical colleagues in the general medical setting. Integrated care is more systematic than the simple co-location of two distinct services since it requires interdisciplinary communication, collaboration, coordination of service delivery, and the shared goal of improved total health for patients.

Integrated care includes staffing, IT, and training elements. Preferred staffing is through psychiatrist led mental health teams that include nurses, social workers, therapists and other mental health professionals, staffed based on the mental health needs of the population being served.

Team members, under psychiatrist supervision may provide therapy, assist in medication management, and address continuity and coordination needs through case and/or disease management. Depending on the clinical setting and organizational requirements, psychiatrist team leaders may lead case consultation team meetings, provide short term ongoing care to patients per the request of primary care physician, train primary care physicians and their staff in basic mental health care, collaboratively oversee screening and intervention for MH/SUDs in the primary care setting, and/or facilitate referral of psychiatrically complex patients for specialized psychiatric intervention, such as cognitive behavioral therapy with exposure (e.g. panic disorder), programmatic behavior modification (e.g. eating disorders), or electroconvulsive therapy (e.g. psychotic depression).

Integrated care depends on IT for tracking of patient progress and helps to flag those individuals who are not responding. Point of service access to treatment algorithms is also a common feature of integrated care that is supported by an integrated IT system. In an integrated model the same chart is used to record all treatment.
The term *collaborative care* is also used and generally is a specific model for integrated care of a population of outpatients with prevalent mental illnesses such as depression. It is critical for psychiatrists to understand that not all models of integrated care include psychiatrists as providers or consultants as a part of the mental health team. However, a recent meta-analysis of 37 collaborative care trials found that the most effective models included a psychiatrist to do caseload supervision and provide selected consultation.\(^{44}\)

*Integrated Care Works*

Integrated care has been shown in 37 randomized trials to significantly improve the diagnosis and quality of treatment of depression in general medical outpatient settings.\(^{44}\) These studies consistently demonstrate improved quality and patient outcomes compared to treatment as usual. Effective collaborative care is a multimodal intervention that includes two key components. The first is use of allied health professionals, such as nurses (termed "depression care managers") to increase the frequency of patient contact. These psychiatrist supervised disease managers enhance patient education and activate the patient to become a partner in care. They track outcomes of depression with a tool like the PHQ-9, document adherence to medication and psychotherapy, and facilitate return visits to the primary care physician or potential referral to a mental health specialist for patients with persistent symptoms. The second is consultation by a psychiatrist who provides back up for emergencies as well as caseload supervision and decision support to primary care physicians. These consultations focus on patients who are not improving with initial treatment.\(^{44}\)

Recent randomized trials of collaborative care depression intervention studies in primary care have also shown that enhanced screening and provision of collaborative care approaches versus usual primary care is associated with improved functioning including job retention and increased vocational productivity.\(^{52, 53}\) In elderly populations, provision of collaborative care versus usual primary care is associated with improved general medical and mental functioning.\(^{54}\)

Depressive and anxiety disorders have been shown to have approximately two-fold higher prevalence rates in patients with chronic medical illnesses such as diabetes, heart disease and COPD.\(^{5}\) Extensive data has now show that comorbid depression in patients with diabetes and heart disease is associated with amplification of chronic disease physical symptoms,\(^{9}\) additive functional impairment,\(^{10}\) poor adherence to self-care regimens (such as diet, exercise, cessation of smoking and taking medications as prescribed—Table 10),\(^{39}\) higher medical costs,\(^{55}\) increased medical complications and mortality.\(^{56, 57}\) Two recent randomized trials of collaborative versus usual primary care in patients with depression and diabetes have shown not only improved depression outcomes but also a high likelihood of savings in total medical costs over a two-year period (Figure 7).\(^{58, 59}\) In diabetic and elderly patients with greater complexity, these cost savings have been shown consistently and annually for up to 5 years after a discrete depression intervention.\(^{60, 61}\)
Integrated Care is Cost Effective

The Agency for Health Research and Quality recently completed an analysis of the value that integrated services bring to the health system. The overall finding was that integrated care programs improve outcomes for patients and, if organized correctly, save money. This Cochrane review found that many of the integrated programs were difficult to sustain financially even when clinical improvement and total healthcare cost savings were well documented. An exception to this was the Veterans Administration system, in which there is less of a division in the way that general medical and mental health services are financed. In the VA system, integrated care can be effectively delivered and is financially sustainable. In fact, the primary deterrent to integrated program viability is related to the current separation of general medical and mental health payment. Change in the reimbursement system is necessary to capture even a portion of the annual $300 billion in extra health service use by those with MH/SUDs.

Other Value-Based Models of Care Integration

The most impressive data, related to the value that the introduction of psychiatric services brings in the medical setting, comes from studies performed in medical patients with depression and to a lesser extent anxiety disorder. Findings from these are detailed above. Many other less substantial, yet compelling, integrated care studies in general medical patients with concurrent substance use disorders, unexplained somatic complaints, delirium, or health complexity are now accumulating (Table 11). These, in addition to the more robust, but generalizable, outcome studies in patients with depression and anxiety provide guidelines for “value added” psychiatric services in the primary care setting as the policy recommendations below are implemented.
Table 11. Health Care Delivery-Based Integration (Improves Outcomes and Lowers Cost)

- Depression and diabetes: 2 months fewer depression/yr; projected $2.9 million/yr lower total health costs/100,000 diabetic members
- Panic disorder in P.C: 2 months fewer anxiety/yr; projected $1.7 million/yr lower total health costs/100,000 primary care patients
- Substance use disorders with medical compromise: 14% increase in abstinence; $2,050 lower annual health care cost/patient in integrated program
- Delirium prevention programs: 30% lower incidence of delirium; projected $16.5 million/year reduction in IP costs/30,000 admissions
- Unexplained physical complaints: no increase in missed general medical illness or adverse events; 9% to 53% decrease in costs associated with increased healthcare service utilization
- Health Complexity: halved depression prevalence; statistical improvement of quality of life, perceived physical and mental health; 7% reduction in new admissions at 12 months


Recommendations

Immediacy of Need—Opportunities of Health Care Reform

With the election of President Obama and an economy that is reeling out of control, healthcare reform has enter into a phase of aggressive fiscal package redesign to stimulate and stabilize the national financial system while attempting to retain quality of care. Few argue that mental health services are unimportant as the healthcare reform debate is waged. In fact, the lack of mental health service availability is increasingly recognized as a significant barrier to health. That is, however, where discussions about psychiatric care typically end as health reform deliberations proceed.

It is only after the bigger questions are answered, e.g. single vs. multiple payor, what is included in basic benefits, sustainable growth rate formulae, definitions about and payment for medical homes, etc., in which all other medical specialties are directly a part of the debate, that issues related to mental health care re-emerge. This is because in the current reimbursement system, mental health and chemical dependence care are a part of a separate payment process. Further, they constitute a very small component of the total health care budget (3% to 5%).

Only after the main decisions about approaches to health and budget appropriations are made are standard mental health allotments determined and work-arounds for special programs identified, such as through grants, foundation funding, etc. Standard and special funding for mental health programs is usually miserly and tightly regulated through utilization review by carved in or carved out managed behavioral health organizations.
There are few funds available to support mental health care in non-psychiatric settings and even less incentive to do so.

General medical payors consider support for psychiatric care outside of their sphere of accountability. As a result, any psychiatric programs in the general medical setting require “extra” funds. General medical and behavioral health plans vigorously oppose these extra dollars coming from their independently administered funding pools. As a result, psychiatric programs in the medical setting are unsustainable even after clinically and financially successful grant or pilot project completion.

So, behavioral and general medical health plans are in stalemate while psychiatrists and their patients suffer the consequences. This is where the data shared in the white paper completes the picture and leads to the Work Group’s APA policy recommendations. Psychiatry is in a time of opportunity. The data show that mental health patients, and especially those with chronic and/or complex illness, are a financial drain on the health system. This can only be reversed if they receive outcome changing care in the medical sector in which they are willing to be seen, i.e. general and specialty medical settings.

Through arguable savings generated through the coordination of psychiatric care in the medical setting, especially in patients with chronic and/or complex illness, traditional and integrated psychiatric services could be supported as a part of a unified total health budget. By unifying the budget, integrated psychiatric care would not be “extra.” Rather, as traditional psychiatric services, it would just be considered a part of health. Secondary effects of transitioning mental health dollars to the medical budget would be that aggressive behavioral health utilization management procedures would be replaced by medical management procedures, that psychiatric illnesses would become a part of all basic benefit packages, that psychiatrists would be in medical provider networks, that coding and billing would become uniform with medical billing procedures, etc. In addition to the potential reduction in the level of total service use by appropriately treated patients in the medical setting, there would also be savings generated through administrative consolidation as managed behavioral health companies folded into integrated medical managed care business practices.

It is a perfect time for psychiatry to become a part of the solution and to capture clinical and financial service support by implementing integrated models that already exist and have established effectiveness. Time, however, is of the essence. It is important that psychiatry transition to payment through general medical benefits as soon as possible. Only after this occurs will psychiatry truly be at the table and a vested player in the larger health reform debate. Psychiatry must become a part of the medical mainstream for stigma to recede, expanded clinical care in the medical setting to occur, and reimbursement for psychiatric care to improve. Importantly, psychiatrists need to be at the table arguing their case for this to happen now and in the future. In today’s segregated clinical care environment, mental health care is and will remain an afterthought.
Policy Position

Mind and body are inseparable parts of the same organism, in feedback loop with each other. Complex biological processes interact with psychosocial dimensions of illness to form a biopsychosocial template. Yet our language remains dualistic, separating "mental" from "physical," consequently leading to disparity and discrimination in access, compromised quality of care, and fragmentation of services. We can better help our patients by identifying similarities between, and comorbidities among, mental illnesses and other medical illnesses; and by integrating delivery of psychiatric and primary care services. We will thus enhance quality, access, outcomes and achieve parity and nondiscrimination.

The Ad Hoc Work Group on the Integration of Psychiatry into Primary Care recommends the adoption of the following policy:

Clinical Reform

- **Psychiatric care should become an integral part of the “team” approach to health improvement in general medical settings. This approach can result in lower outpatient and inpatient medical costs.**
  - **Outpatient Models:** Research shows that a collaborative team approach, which includes primary care case managers and their supervision by a psychiatrist in general medical settings and psychiatric consultation and treatment for patients who do not get better, improves clinical and cost outcomes in general medical patients with anxiety and depression with and without co-existing psychiatric and medical conditions, such as diabetes and depression. The APA recommends support for such programs for all persons suffering from mental illness and substance use disorders in general medical settings.
  - **Inpatient Models:** The APA urges support for the development of programs that allow concurrent general medical and mental health intervention for high-cost and complex patients with co-existing general medical and mental health problems in general hospitals. These should include delirium prevention programs, proactive psychiatric team consultation services, and complexity intervention units.

Fiscal Reform

- **The fulfillment of medical parity, meaning that psychiatric and other mental health services and reimbursement are comparable to general medical health and paid through general medical benefits. This can be achieved through the phased consolidation of general medical and mental health budgets.** (It should be noted that without this fiscal component, the clinical reform outlined above would not be deliverable.)
  - Fulfillment of parity legislation dictates that payment for psychiatric and other mental health services and for psychiatric facilities be consolidated with general medical health, transitioning into one “health” budget.
• Mental health professionals and facilities should become a part of general medical networks and the health facility infrastructure, paid on par with other practitioners and facilities from one funding pool.

• The APA recommends reimbursement procedures for clinical programs, including clinical services sustaining payment for billed codes, that encourage high-quality mental health care and, most importantly, for services directed at enhanced outcomes using evidenced-based methods as an essential part of fiscal health reform.

Specific Actions

Immediate

9. Develop an education campaign for APA leadership and general membership about the value of integrated care. (Emphasize that this will enhance and expand practice opportunities for psychiatrists in the future and reduce reimbursement hassles regardless of practice location. The changes recommended in this white paper should not change support for existing psychiatric practice activities.)

10. Meet with the leadership of psychiatry and other primary and specialty medical care disciplines individually and through organizations, such as the AMA, American Osteopathic Association, the American College of Physicians, and American Academy of Family Physicians to explore strategies for reducing barriers to the adoption and implementation of integrated and collaborative care. Meetings should also be included with subspecialty psychiatric groups to explore their collaborative work, such as that done by the American Academy of Child and Adolescent Psychiatry with the American Academy of Pediatrics. Consideration should be given to putting on an interdisciplinary “summit” on the integration of psychiatry into medical settings.

11. Survey APA Councils for recommendations regarding barriers to and strategies for the implementation of integrated and collaborative care within their areas of expertise.

12. Involve the APA Assembly of District Branches in developing recommendations and implementation strategies.

13. Develop a strategy to promote integrated and collaborative care to corporate healthcare purchasers, government programs, and medical health plans.

14. Communicate with the World Health Organization to identify opportunities to support initiatives that support the WHO, “No Health Without Mental Health” campaign.

15. Develop recommendations on strategies to complete the intent of legislation on parity for mental and general medical health care, i.e. by making mental health and substance use disorder care a part of total (general medical and mental) health benefits.

16. Meet with the APA Government Relations staff to develop state advocacy strategies that will identify potential opportunities to support the implementation of integrated care through state government and state insurance regulations.
Mid and Longer Term

9. Meet with Federal and State policy makers to propose official recognition of the public health significance of untreated mental illness and the importance of collaborative care in changing this.

10. Meet with APA Healthcare Systems and Financing, Government Relations, and Communications staff to develop an advocacy strategy that will identify potential opportunities to support the implementation of integrated care in federal healthcare programs. Include consideration of federal parity laws and related regulations.

11. Develop a toolkit that will provide practice implementation strategies for psychiatrists and primary care physicians who want to implement integrated care.

12. Review current CPT coding for opportunities to support care coordination and integrated care.

13. Develop templates and timelines for transitioning mental health and substance use disorder care to general medical CPT coding practices.

14. Review current residency training requirements toward ensuring that all psychiatry residents are exposed to training in integrated care, including the supervision of mental health teams.

15. AAMC and residency directors in collaboration with APA Office of Education should develop psychiatric educational programs about the assessment and treatment of patients with acute and chronic comorbid medical illness and mental health/substance use disorders for medical students, psychiatric and non-psychiatric residents, and other health professionals as a part of collocated and integrated inpatient and outpatient clinical settings.

16. Initiate demonstration projects on collaborative care through academic institutions, medical home initiatives, community mental health centers, and community health centers.

Vision for the Future

Since the introduction of managed behavioral health in the early 1980s, a system in which psychiatric services are paid through independently managed funds from all other healthcare services, access to psychiatric care in the clinical locations where the majority of those with mental disorders are seen, i.e. the primary care setting, has been severely and persistently curtailed. This is, in large part, the direct result of the segregated management of payment for general medical and psychiatric services. In order to improve access to and continuity of psychiatric with general medical care in an environment of parity for healthcare, it will be necessary to consolidate independent mental health budgets into general medical health budgets and to reimburse for psychiatric services as a part of general medical benefits. By doing so, it will be possible to co-locate general medical and psychiatric care regardless of clinical setting and to initiate efficacy-based models of care collaboration between psychiatrists and their non-psychiatrist physician colleagues.

Future psychiatrists and their staff should:
• Be involved in the care of the majority of psychiatric patients with serious and persistent mental illness and with health complexity (those with suboptimally addressed biological, psychological, social, and health system factors creating barriers to improvement) in both the general medical and psychiatric settings through direct clinical services, supervision of psychiatric teams and/or care managers, and/or assistance to non-psychiatric practitioners
• Be geographically co-located with general medical clinicians in most medical settings, share common medical records, and interact regularly about comorbid and/or common patients
• Be paid using the same coding and billing procedures as non-psychiatrist physicians and support staff from a single “health care” benefit set
• Routinely provide clinic and general hospital-based education about and treatment of psychiatric disorders in general medical patients seen in non-psychiatric settings to medical students, psychiatric and non-psychiatric trainees, and other health professionals
• Routinely assess and treat medical comorbidities in psychiatric patients with assistance from non-psychiatrist physicians and/or their medical teams
• Experience research and funding opportunities for investigation of the interaction of general medical and psychiatric disorders and usable health care models which coordinate treatment since the organization of and payment for health services necessarily allows integration of the care for patients with combined illness
  • Increased integrated care grant opportunities
  • Increased health complexity grant opportunities

Psychiatric patients, and especially those with health complexity, should:

• Routinely access and obtain the majority of their evidence-based general medical and psychiatric care with minimal hassle while visiting their “medical home” due to geographic co-location of general medical and psychiatric clinicians, mental health teams under their supervision, and service locations
• Receive improved care for medical conditions when seen primarily in the psychiatric setting either due to geographic proximity of general medical services, e.g. co-location of community health and mental health in the same building, or through reverse collaborative arrangements in which general medical services are “part of standard care” in psychiatric clinics or hospitals
• Experience improved psychiatric and general medical health clinical outcomes, abbreviated disability and impaired function, and reduced total health service use and cost

**References**


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