Primary Care Providers' Role in Mental Health

This is one of a series of issue briefs by the Bazelon Center on the integration of mental health in healthcare reform. They offer policy recommendations for:
♦integration of mental health in primary care;
♦medical homes;
♦chronic care management;
♦integration of mental health in the public health system;
♦the role of public insurance programs (Medicaid, SCHIP and Medicare); and
♦improving the quality of care.
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Primary care providers are the backbone of our healthcare delivery system. As part of their overall focus on a person's health and wellness, they are playing an increasingly important role in identifying and treating mental disorders. Primary care services are also critically important for individuals with severe mental illnesses, whose physical health needs are often overlooked and who often have routine contact only with mental health providers.

The World Health Organization has called integrating mental health services into primary care the most viable way of closing the treatment gap for untreated mental illnesses, characterizing primary care for mental health as affordable and an investment that can bring important benefits.[1] WHO also states that integration is most successful when mental health is incorporated in health policy and legislative frameworks accompanied by adequate resources.

One way to support primary care providers in delivering this holistic healthcare is to integrate mental health services with physical healthcare in the same location. There is considerable evidence that this is highly effective.[2] Where primary care and mental health providers are not co-located, coordination is more difficult but no less important.

Background

Primary care providers now furnish over half of mental health treatment in this country[3] and about 25 percent of all primary care recipients have diagnosable mental disorders (most commonly, anxiety and depression). Yet many mental health problems are not identified in primary care, perhaps as many as 50 percent. These undiagnosed disorders need to be properly identified and treated.[4]

Healthcare reform policy should support and encourage practices that integrate mental health into primary care. The most effective linkage occurs when behavioral health specialists work side-by-side with the primary care provider. There are many advantages to strategies that co-locate primary care and mental health providers. Consultation becomes routine, patients follow up with their providers and are more willing to keep appointments as the stigma of visiting a mental health office is removed, and quality of care and outcomes improve. More than 35 randomized controlled trials have shown the effectiveness of collaborative care models in treating mental illness.[5]

To make it easier for primary care providers to co-locate a behavioral health specialist within the primary care practice, health reform policy should ensure that this is financially viable by removing reimbursement barriers (see recommendations below). Currently, there are few economic incentives for collaboration and co-located care.
Mental health concerns need to be fully addressed by all primary care providers, regardless of co-location. Collaboration should still be the norm. Studies have shown, for example, that collaborative care models improve outcomes, functioning and quality of life and are

cost-effective for treating depression.[6] Health reform policy should encourage primary care providers to:

- Screen for mental health issues,
- Assess and furnish care to those with mild or moderate disorders or whose severe mental disorder is stable;
- Form strong working linkages with mental health specialty care for complex cases, including sharing critical patient information, such as medication data.

Many current proposals for healthcare reform encourage a more systematic emphasis on prevention. Targeted mental health prevention and screening could be especially valuable. A recent review of the literature found that lifetime mental disorders often start by the mid-teens; three quarters of such disorders are identified by the time patients are in their mid-20s. Severe disorders are typically preceded by less severe conditions that are generally not brought to clinical attention.[7] This suggests that primary care providers have significant opportunities to identify behavioral health problems early and intervene in a manner that prevents further deterioration and avoids significant future costs. Screening and early intervention are priorities that may not only improve outcomes for individuals but also, over time, provide savings to the system.

Preventive programs for particularly high-risk populations can hold great promise of improving care while reducing overall costs to the system. Primary care providers should be encouraged—and adequately reimbursed—to:

- Incorporate behavioral health screenings into well-child check ups from early childhood through adolescence;
- Screen for depression and substance use in pregnant and perinatal women; and
- Provide anticipatory guidance and coaching to caretakers of children as a component of pediatric care to ensure that children's social/emotional development needs are met.

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Primary care cannot address all needs. When co-location is not an option, it is important to create linkage between practitioners located in separate settings. Primary care providers need specialty mental health back-up and therefore need easy consultation—by phone, telecommunications link or in person. Barriers to this consultation need to be removed. Greater use of electronic records would make it easier to communicate. Payment for the two providers to consult on a specific patient is necessary. Psychiatric consult lines can be very helpful to primary care, as can access to mobile mental health services that can respond when a patient is in difficulty.

Collaboration is especially important for individuals with severe mental illnesses whose primary healthcare contact is more likely to be a specialty provider or public mental health agency than a primary care physician. For many reasons, these individuals tend to use fewer medical services.[8] Individuals with mental illnesses report barriers to care (such as transportation problems) more often than the general population (half of individuals with mental illnesses, compared with only 19 percent of others). Again, the best strategy is co-location—in this case, placement of primary care within the specialty mental health program. [9]

Integrated care— whether delivered by individual primary care providers, group practices, integrated health plans or mental health agencies—can produce better outcomes, but only if appropriate payment mechanisms are in place.

Policies that act to undermine the concept of integrated care should therefore be swept away.

Recommendations

Health policy should facilitate, not impede, integrated care. The following changes to reimbursement policies would promote integrated care:

- Insurers must allow primary care providers to bill for mental health interventions that take longer than the standard 10-minute visit. While many insurers allow primary care providers to bill through codes that enable various increments of time up to 50 minutes for a mental health visit, others limit payment to the code for short visits.
- Entities with co-located primary care and mental health providers should be able to bill all payers for more than one visit on the same day, such as a primary care visit and a mental health visit. (At present there are confusing policies in Medicare, and some state Medicaid programs and private insurers have specific policies that deny payment for two services to be billed on the same day by the same entity). When a patient can see two providers on the same visit this is the most effective and efficient approach and it avoids the individual's failure to follow up on a referral.

Reimbursement rates in private and public plans need to be set at levels that encourage, rather than discourage, integrated care.

- All payers should reimburse for the cost of consultation between two practitioners around the needs of a single individual.
- Reimbursement rates in private and public plans need to be set at levels that encourage, rather than discourage, integrated care. For example, general hospitals are the most integrated form of inpatient care, but many are eliminating their psychiatric units and beds because of financial concerns. Cost-containment approaches that result in providers' avoiding certain high-cost individuals are counter-productive.
- Payment mechanisms for mental health services furnished by both primary care and mental health providers should reflect the intensity of care, with higher rates for individuals with more severe and complex disorders. Rates need to be adjusted to reflect the increased time required to treat more complex conditions, which necessitate consultation, case management and significant follow-up. Integration of care will be discouraged if it is too costly for primary care providers to treat certain mental health disorders or to recoup the cost of the co-located behavioral health specialist.

National health policy should encourage organized arrangements of co-location of providers. One approach is medical homes (see issue brief on that topic.) Other approaches, however, should also be encouraged.

The Health Services and Resources Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) should have funding to initiate

various demonstration programs that integrate primary care with mental health care for individuals who use public-sector services. Evaluations of the outcomes, costs and cost-effectiveness of these models should be conducted.

1 World Health Organization (2008). Integrating Mental Health into Primary Care: A Global Perspective. ISBN 9789241563680. Available at: www.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=15&codcch=739

2 One concept that would link primary care to various other services, including mental health, is that of medical homes. Given the importance of the medical home concept, the Bazelon Center has produced a separate issue brief on this topic. There is overlap between this issue brief and the Medical Homes issue brief in that both deal with the need for integration and collaboration between primary care and mental health providers. However, since not everyone will be enrolled in a medical home, this issue brief addresses how to improve integration of mental health within primary care in other settings.

3 Reiger, D., Narrow, W., Rae, D., et al. (1993). The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry,* 50, 85–94.

4 U.S. Dept. of Health and Human Services. (2001). *Report of a Surgeon General's working meeting on the integration of mental health services and primaryhealth care*. Rockville, MD: Author. www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.PDF4.

5 Thielke, S., Vannoy, S. & Unützer, J. (2007). Integrating mental health and primary care. *Primary Care: Clinics in Office Practice, 34,* 571-592.

6 Unutzer, J., Schoenbaum, M., et al. (2006). Transforming mental health care at the interface with general medicine: Report for the President's Commission on Mental Health. *Psychiatric Services*, 57(1), 37-47.

7 Kessler, RC, et al. **Age of onset of mental disorders: a review of recent literature**. *Current Opinion in Psychiatry*. 20(4):359-364, July 2007.

8 Craddock-O-Leary, J., Young, A., Yano, E., Wang, M., & Lee, M. (2002). Use of general medical services by VA patients with psychiatric disorders. *Psychiatric Services*, 53, 874-878.

9 For more information on this option, see the issue brief on Medical Homes.