FINAL

I. Position Statement

Title: ***Psychiatry & Primary Care Integration Across the Lifespan ****

Issue: Our current American health system is fragmented, inaccessible and discriminatory *vis a vis* psychiatric physicians and people suffering from psychiatric disorders. The Action Paper on Psychiatry & Primary Care Integration, consistent with our APA Vision & Mission of advocating for our patients & the profession, was introduced before our APA Assembly in May 2008, and was endorsed by unanimous consent.

APA Position:

- Access to and payment for clinically appropriate services provided by psychiatrists should be included as an essential feature in medical/health home initiatives.
- Parity of benefits design for beneficiaries as well as parity in payment for all physicians, particularly psychiatric that does not discriminate by location of service or diagnosis should be provided.
- Psychiatrists should have choices of participation in a new health system, such as fully integrated clinicians and/or managers of the system, as collaborative care partners, and as consultants to it.
- The exact financial formula for these choices should be negotiated such that it is compatible with parity and nondiscrimination regarding both psychiatric patients and psychiatric physicians

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Adoption Date:

**The title of the position statement was updated as a result of review and feedback from the Council on Children, Adolescents and their Families*

II. Resource Document: *Psychiatry & Primary Care Integration: Challenges & Opportunities,* Eliot Sorel, M.D. and Anita Everett, M.D.

Psychiatry and Primary Care Integration is one of the contributions our APA can make to our country's current discussion, debate and policy formulation on health insurance and health system reform. This resource document is derived from the original Action Paper of May 2008, the BOT work group white

paper on psychiatry & primary care integration completed in May 2009, dialogues with APA BOT and Assembly leaders throughout 2009, testimony by Eliot Sorel, M.D., before the BOT on September 11th, 2009, Dr. Roger Peele's motion at that BOT meeting, reviewed by the Council on Advocacy & Government Relations, edited by the Council on Advocacy and Government Relations on October 20, 2009, and amended by the BOT.

A. Challenges

1. Access. *Health Affairs* describes the access to mental health care deficit as follows:

> "About two-thirds of primary care physicians (PCPs) reported in 2004–05 that they could not get outpatient mental health services for patients—a rate that was at least twice as high as that for other services. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access. The probability of having mental health access problems for patients varied by physician practice, health system, and policy factors. The results suggest that implementing mental health parity nationally will reduce some but not all of the barriers to mental health care". (1)

The current *Mental Health Parity and Addiction Equity Act of 2008*, alone, will not suffice to resolve the multi-determined, markedly deficient access to mental health care in our fragmented, discriminatory health system, described above.

2. Quality

The National (US) Comorbidity Survey Replication (NCS-R) completed four years ago (same time frame as the *Health Affairs* reference) indicates that PCPs treat many more psychiatric patients than do psychiatrists but that only 12.7% of those patients receive minimally adequate care. (2)

3. Finances

A recently completed analysis by Milliman, a leading US actuarial firm, demonstrates that psychiatric physicians are paid less than other physicians for virtually the same usual and customary outpatient services that each provides. Relative to Medicare allowable levels, other physicians were paid at a 116.6% rate for typical E&M visits, while psychiatric physicians were paid just 96.8% when both services were provided within managed care networks.(3)

4. Consequences: Comorbidity, chronicity, disability, premature death & dying
The convergence of diminished access, fragmentation, lack of integration, minimal quality of psychiatric care in primary care settings – where most patients are seen and many more who need to are not seen because of above stated barriers – and discriminatory payments vis-à-vis psychiatric physicians, coupled with continued shame, stigma and discrimination, result in significant augmentation of comorbidity, chronicity, disability, premature death and dying. Conservative estimates of the costs of comorbid and untreated depression with other chronic diseases augments the health care and disability costs for the US patient population, to between $130.00 and $350.00 billions annually, possibly more. (4)

B. Opportunities

1. Psychiatry and primary care integration works.
Randomized controlled trials and clinical research evidence produced in the last decade clearly and convincingly indicate that psychiatric care can be integrated into primary care. Integrated care models increase access, quality and clinical outcomes for mental disorders. (5, 6, 7)

2. Psychiatry & primary care integration would benefit large populations
It is estimated that for a population of one million health insured Americans, there are about 1,760,000 visits to a primary care physician in a year and 72,000 member visits to psychiatrists per year in an average managed care plan. In the primary care population, it is likely that 25% have comorbid and diagnosable psychiatric disorders in need of psychiatric and/or integrated care: projecting 440,000 visits per year. The gap between the numbers seen by psychiatric professionals and the numbers in need is over 368,000 potential visits. These individual visits are rarely, if ever, identified and addressed in the current fragmented health system with the consequences aforementioned. The integration of psychiatric care and primary care has consistently been demonstrated [in numerous randomized controlled trials (5, 6, 7)] to enhance access, improve quality, enhance individual outcomes and diminish costs. (3)

References:

1. Cunningham, P.J., Beyond Parity: Primary Care Physicians' Perspective on Access to Mental Health Care, *Health Affairs* 28, no. 3 (2009): w490–w501 (published online 14 April 2009).
2. Kessler, R.C., *et al*, Prevalence, Severity and Comorbidity of Twelve-Month DSM IV Disorders in the NCS-R, *Arch Gen Psych*, Vol 62, pp 617-627, June 2005).
3. Melek, Steve, Milliman actuarial firm, July 2009.
4. Melek, Steve, *Milliman Report*, July 2008
5. Katon, W., *et al,* Depression & diabetes, *Diab Care*, 29:265-270, 2006
6. Gilbody, S., *et al*, Educational and organizational interventions to improve the management of depression in primary care: a systematic review, *JAMA* June 18 2003; 289 (23):3145-3151
7. Schoenbaum, M., *et al,* Cost-effectiveness of practice-initiated quality improvement for depression: results of a randomized controlled trial. *JAMA* September 19, 2001, 286 (11); pp. 1325-1330

III. Implementation Document

The American Psychiatric Association in collaboration with Primary Care Professional Organizations and other specialty organizations

- Advocate, at state and federal levels, for collaboration and integration of psychiatry and primary care, enhancing quality, access and accomplishing parity and nondiscrimination for our patients and the profession,

- APA work with the American College of Physicians, American Academy of Family Physicians, American Association of Medical Colleges and other appropriate professional and advocacy

organizations to develop collaborative training initiatives on psychiatry and primary care integration.

- Leadership within APA, in the BOT and the Assembly Executive Committee continue to work on other initiatives that are aligned with increasing access for underserved and not served Americans to psychiatric specialty care through policy that supports the integration of psychiatric and primary care services in all medical and mental health settings

- The Council on Advocacy and Government Relations, the Council on Healthcare Systems and Financing, and our APA AMA delegation be the designate lead Councils for implementation