Psychiatry & Primary Care Integration: Challenges & Opportunities

APA Policy Brief

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Psychiatry and Primary care Integration is one of the contributions our APA can make to our country's current discussion, debate and anticipated policy formulation on health insurance and health system reform. This policy brief is generated in response to recent dialogues, between members of our APA BOT, Assembly and ***psychiatry & primary care integration*** white paper authors. We have also reviewed the Stotland report on access to care. Our policy brief is intended to clarify, explicate and be catalytic toward APA policy decisions and actions for implementation of the ideas and models presented, earlier, this spring.

CHALLENGES

1. Access

A recent, relevant article in *Health Affairs* describes the access to mental health care deficit:

> "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 resolve the multifactorially determined, markedly deficient access to mental health care in our fragmented, discriminatory health system, eloquently 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 both 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)

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 and primary care, integrated and collaborative, effectively enhance access, quality and outcomes. (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 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)

3. Policy Recommendations, APA actions

The BOT endorse the Integration of Psychiatry and Primary Care through the development of a succinct position/policy statement, advocating the following:

- Psychiatry must be included as an essential component in all federal and state funded medical home demonstration projects.
- 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

- 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 is to be negotiated such that is compatible with parity and nondiscrimination regarding both psychiatric patients and psychiatric physicians
- APA work with ACP, AAMC 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 AEC 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

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