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Opportunities and Challenges of Integrating Mental Health Services into Primary Care

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Mental health disorders are among the most common conditions evaluated and treated by general internists. By some estimates, over one third of all mental health care in the United States is provided by primary care clinicians, and 70% of primary care clinicians' time involves managing complex psychosocial issues. Furthermore, psychological disorders such as depression or post-traumatic stress disorder influence the incidence and prognosis of comorbid physical illnesses. This strong relationship between primary care and behavioral medicine provides a clear rationale for integrating behavioral medicine into the general internist's practice. Yet, historically, medicine has segregated the care of the body and the mind into two silos. Economics have contributed to the isolation between general internists and behavioral specialists. Due in part to poor reimbursement from insurance companies, many of us are unable to link our patients with high-quality affordable behavioral specialists.

The last decade has been marked by two signature pieces of federal legislation that have promised to transform this paradigm. The Mental Health Parity and Addiction Law, enacted by Congress in 2008, requires group health insurers that offer mental health benefits to provide coverage for mental health conditions at the same level as provided for physical conditions. The Affordable Care Act (ACA) of 2010 mandates that Medicaid benchmark plans and plans operated by state-based insurance exchanges offer behavioral services. The ACA also fosters the development of integrated care models (e.g. primary care medical homes and accountable care organizations) that aim to replace fee-for-service with bundled payments for high-quality patient care. The hope is that this will create an economically viable model for integrating behavioral medicine specialists into primary care settings.

At the same time that policy-makers have been seeking to redress the imbalance between access to mental health and physical health services, researchers have been demonstrating the effectiveness of new approaches to integrating mental health with primary care. One of the studies that has revolutionized the field is the IMPACT trial.[1] This study showed that a primary care-based program of enhanced depression screening and treatment can dramatically improve mental health outcomes among patients with depression. A key component of this program is the availability of a collaborative team of mental health specialists including a therapist trained in problem-solving therapy and a psychiatrist for the most challenging cases. Adapted versions of this model of care have successfully reduced depressive symptoms in patients with comorbid health conditions in a cost-effective fashion; in some studies, this team-based approach has improved physical health outcomes as well.[2]

Given these recent advances in policy and evidence-based mental health medicine, we wondered if the general internists on the frontline of caring for patients with mental disorders were noticing any positive changes. Has there been an increase in the availability of mental health services for their patients? Are the decades-old cultural walls between physical and mental health specialists disintegrating? To answer these questions, we canvassed our colleagues in the SGIM Mental Health Interest Group to gain their perspectives. Below, we summarize some of the key themes that emerged from these interviews.

For many general internists—especially those practicing outside large cities—finding affordable mental health care for patients remains a challenge. Some internists even feel that access to specialists is going in the wrong direction, with shrinking primary care resources for co-located social workers or other behavioral specialists and ongoing challenges identifying external referrals. Some well-intentioned psychologists wishing to locate their practice in the academic primary care setting have found that divisions of general internal medicine, while sensitive to the need for increased access, do not have a viable model to fund mental health specialists in the academic primary care setting. Whether implementation of the ACA will increase accessibility to specialists in the coming years remains to be seen.

Many academic-based general internists observe ongoing barriers to accessing mental health resources within their own institutions. There is confusion as to how to refer patients to these resources. Whereas referring to medicine or surgical specialists often only requires a click in the electronic health record, psychiatry resources often require finding a mysterious phone number, faxing a form, or having patients make the appointment themselves. Psychiatry

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clinics are perceived to have inordinately long wait times for new assessments, and psychotherapy is often unavailable for individual counseling or in languages other than English. Even when patients are successfully referred to behavioral specialists, few receive any feedback regarding the referral, and notes are often kept in separate charts. Hence, cultural and structural barriers remain in place for many internists.

Some internists practicing in settings that have co-located specialists report missed opportunities for integrating specialists into their practice. As a result, these internists continue to refer many of their patients to community sites even though they have in-clinic resources. The mental health specialists located in general medicine clinics, in return, express frustration due to high "no show" rates and due to patients who arrive without any understanding of the reason for the referral. While these co-located programs are often initially instituted with idealistic aspirations for integrated care, without physician champions, integration withers away.

We did hear stories that provide reason for optimism. In some institutions, notably at outpatient practices of the Departments of Veterans Affairs, general medicine and behavioral specialists know each other personally, can approach one another with questions, and are confident that their patients can be seen in a timely fashion with notes shared on the same system. The high burden of psychological problems among returning Veterans has provided the impetus for increased behavioral resources in VA settings. There have been positive changes in other settings as well. In some cases, positive experiences with collaborative care chronic disease management programs for physical disorders such as diabetes or heart failure have led to interest in similar programs organized around depression. In one especially successful program, a recently implemented IMPACT-style depression screening and treatment program identified and treated almost one third of a major academic clinic's patients for depression! Ongoing difficulties in accessing specialty care reinforce the need for team-based mental health care in the primary care setting, and now the program is firmly entrenched at that site.

Initiatives to provide seed funding for primary care medical homes have also enabled the development of integrated care models in some clinics. Programs to prevent 30-day readmissions have also invested in behavioral resources that support general internists. In a cautionary tale, however, some general internists experience resistance from psychiatrists who are uncomfortable with primary care serving as the home base for mental health treatment—and even more so are uncomfortable with general internists leading such programs. This highlights the need for increased cultural exchanges between generalists and specialists when attempting to integrate the two silos. Other commonly reported barriers to sustainable integrated models include outdated assumptions about requirements for mental health carve-outs and for segregated billing, electronic health records, and hospital administrators who have not kept abreast of the latest legislative changes.

What is the way forward? How can we broaden and strengthen the integration of primary care with behavioral medicine? General internists almost universally recognize a need for better access to mental health services either through co-location or stronger linkages to specialists in psychiatry departments or in the community. Yet for practice transformation to take place, general internists must champion such programs. In a thought-provoking editorial in *JGIM*, the possibility of developing a new specialty in general internal medicine—the Primary Care Behaviorist—was proposed.[3] This would enable us to train and promote a cadre of general internists with a passion for taking advantage of recent legislative and research findings to truly integrate primary care with mental health services. Another way forward may be to focus our efforts on internal medicine residency training. Unlike our colleagues in family medicine, we have few explicit requirements for behavioral medicine during our training even though mental health issues are central to the management of the whole patient. Another approach will be to harness the lessons of implementing depression care programs as a means to expand collaborative care mental health services for a wider spectrum of common mental disorders. Recent legislation does seem to be spurring the development of such integrated models in some settings. There is already abundant evidence that integrated care will lead to better outcomes for our patients. Now is the time for general internists to come together with mental health specialists to accomplish this mission.

References

1. Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA 2002; 288(22):2836-45.
2. Katon W, Russo J, Lin EH, et al. Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. Arch Gen Psychiatry 2012; 69(5):506-14.
3. Feldman MD, Feldman S. The primary care behaviorist: a new approach to medical/behavioral integration. J Gen Intern Med 2013; 28(3):331-2.

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