Mental Health, Primary Care Collaboration Urged

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NASHVILLE, TENN. — Integrating mental health and primary care has the potential to reduce medication mistakes and improve communication among providers, experts said at the annual conference of the National Academy for State Health Policy.

"This is a medical error reduction opportunity as well as a quality and cost opportunity," said Joseph J. Parks Jr., M.D., a psychiatrist and medical director for the Missouri Department of Mental Health.

The status quo isn't working, he said. Individuals with mental illness have increased or early mortality, have high rates of medical comorbidity, and receive inadequate and poorly coordinated health care.

Mental illness also predicts underutilization of medical services. A study of older patients with psychiatric disorders found that individuals with diabetes were less likely to receive more than one medical visit if they also had schizophrenia, bipolar disorder, or posttraumatic stress disorder. Patients with hypertension and any psychiatric disorder were also less likely to have more than one medical visit (Psychiatr. Serv. 2002;53:874-8).

There are several models for integrated mental health and physical care, including embedding primary care in a mental health program, creating a unified primary care/mental health program with common administration and financing, and improving collaboration between mental health and medical providers.

Evidence seems to show that trying to create linkage is difficult, Dr. Parks said. "Collaboration is basically an unnatural act between separate organizations," he said. While this model is easier to set up initially, it is harder to make successful over the long run.

Models where primary care is embedded in mental health clinics or primary care and mental health programs are unified are harder to set up initially but easier to operate day to day, he said.

In general, the colocation of services is popular with both patients and providers. On the provider side, it allows physicians and other providers to have a more accurate understanding of one another's incentives, methods, and constraints, Dr. Parks said. Colocation also allows physicians to maintain a single clinical record, which requires less time and creates less potential for errors.

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For patients, it breaks down some of the barriers to care, said Susan C. Braun, a nurse practitioner and project director of the Center for Integrated Health Care at the University of Illinois at Chicago.

She runs a program that brings primary care services into an established psychiatric rehabilitation program. That setup allows mentally ill patients to access medical services without going to a large medical center. Instead, they are cared for in a familiar setting, she said.

Providers at Cherokee Health Systems Inc. in Talbott, Tenn., have taken the opposite approach. There, a behavioral health consultant is embedded with the primary care team. For example, a behaviorist is involved in all well-child visits, said Dennis Freeman, Ph.D., chief executive officer of Cherokee Health Systems. Behaviorists also manage the psychosocial aspects of chronic and acute diseases, address lifestyle and health risk issues, and comanage treatment of mental disorders.

Dr. Freeman said that state regulators and policy makers should reject carved out payments for mental health services because the majority of these services will continue to be delivered by primary care physicians. And he encouraged more payers to implement the Health and Behavior Assessment/Intervention CPT codes 96150 through 96155 that were issued in 2002. The codes are for use by nonphysicians for services involving the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.

Contractual requirements and financial incentives through state Medicaid programs will also help encourage integration of services, Dr. Parks said. ■