COMMENTARY

The Role of Family Physicians in Mental Health Care Delivery in the United States: Implications for Health Reform

Benjamin F. Miller, PsyD, and Benjamin Druss, MD, MPH

The battle for connecting the mind and the body is seen every day in the largest platform of health care delivery: primary care.[1,2] More care for mental health, behavioral health, and substance use is provided in primary care than any other health care setting.[3,4] However, the historical fragmentation that has divided the mental health system from the physical health system has meant that collaboration between primary care and specialty mental health care is a challenge.[5–7] This lack of integration remains a barrier to improving quality, outcomes, and efficiency of the delivery of care.[8,9] Having 2 separate systems to take care of patients' medical and behavioral health needs[10,11] can result in high costs, low satisfaction, and poor outcomes, including premature mortality.[5,7,12–18]

Under the Patient Protection and Affordable Care Act, millions of Americans will now have insurance that will include mental health as an essential health benefit. In addition, the Mental Health Parity and Addiction Equity Act assures that mental health benefits will be covered on par with general health benefits.[19] This new legislation holds the potential to address these longstanding problems with unmet need, but only if there are providers able and willing to provide treatment. Some authors have expressed concern that rural areas— and possibly urban areas as well—may experience an acute shortage of mental health providers.[20] However, regardless of setting, all providers must continue to work to identify mental health conditions to better assess what they are doing or not doing for population health management.[21,22] Increasing family physicians' understanding of the importance of addressing mental health is a critical step toward better addressing this problem.

As Xierali et al.[23] highlight, there is great potential for family physicians to help fill the mental health gap in the United States. There are nearly twice as many family physicians as psychiatrists in the United States, and family physicians are more likely than psychiatrists to be situated in rural areas. The authors report that about 40% of family physicians report providing mental health services in urban areas, with up to 52% providing mental health services in more rural settings (rural-urban continuum codes 7–9).

Psychiatrists, like other specialist groups, tend to cluster in urban regions, potentially reducing access to mental health care in rural areas. Xierali et al.[23] suggests that family physicians can help fill this need. While this is indeed an ambitious goal and, as some might argue, one that medicine as a whole has been pursuing for decades,[24] the assumption that one provider can adequately address all of a patient's needs is being increasingly replaced by the necessity of teams and team-based care.

As the article highlights, only 43% of family physicians nationwide provide mental health care, which begs the question, Why aren't more family physicians providing mental health care? Lack of knowledge, competing work demands (too busy providing other types of services), and payment and reimbursement issues could all be

Submitted 21 December 2012; revised 21 December 2012; accepted 21 December 2012.

From the Department of Family Medicine and the Office of Integrated Healthcare Research and Policy, University of Colorado School of Medicine, Aurora (BFM); and the Department of Health Policy and Management, Rollins School of Public Health, Emory University, Atlanta GA (BD).

Funding: none.

Conflict of interest: none declared.

Corresponding author: Benjamin F. Miller, Department of Family Medicine, Office of Integrated Healthcare Research and Policy, University of Colorado School of Medicine, Mail Stop F496, Academic Office 1, 12631 East 17th Ave., Aurora, CO 80045 (E-mail: Benjamin.miller@ucdenver.edu).

See Related Article on Page 114.

playing a role. These issues need to be addressed in how we train family physicians, how primary care practices are structured, and how reimbursement is provided.

Nonphysician mental health providers are far more numerous than psychiatrists and family physicians.[25] To address the population's need for mental health, primary care teams should include psychologists, social workers, and nurses to help extend the reach of physicians.[8] Such team-based integrated models use allied professionals to provide treatments such as psychotherapy, care managers to coordinate care, and registries and other health information technology to organize delivery of care.[26,27] These integrated programs are being used already in rural settings with low concentrations of psychiatrists and other mental health providers, such as Alaska.[28] In addition, new technologies such as telemedicine can also be used to address gaps in mental health care in rural settings.[29]

Primary care is currently witnessing a substantial redesign through the patient-centered medical home.[10,30–32] This redesign affords primary care the opportunity to discuss ways to better deliver comprehensive care for patients with comorbid mental health conditions.[33] Contemporary evidence supports the notion that primary care can, and should, integrate mental health providers into care teams.[25,34–37] However, these models are not yet in widespread use, and there are still challenges in paying for integrated care models. For example, having separate mental and physical health payment structures and reimbursement practices often is a barrier to better integration of care and leaves primary care to rely on referrals to mental health specialists.[38,39] In the absence of coordination, referral alone may result in limited follow-up and poor outcomes of care.[4,40–42]

This policy brief suggests that family physicians are an important and currently underutilized resource for improving access to mental health care. Their potential will best be realized if they are appropriately trained and supported, and if practices are restructured to include allied mental health providers, care managers, and specialist consultants and use information technology such as registries and telemedicine to support comprehensive and integrated health care. Models such as these are beginning to take hold, and we now have an opportunity to make the integrated health care vision real.

References

1. deGruy F. Mental health care in the primary care setting. In: Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. Primary Care: America's Health in a New Era. Washington, DC: Institute of Medicine; 1996.
2. Green LA, Fryer GE Jr, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. N Engl J Med 2001;344:2021–5.
3. Kessler R, Stafford D, eds. Primary care is the de facto mental health system. In: Kessler R, Stafford D, eds. Collaborative Medicine Case Studies: Evidence in Practice. New York: Springer; 2008.
4. Kessler RC, Demler O, Frank RG, et al. Prevalence and treatment of mental disorders, 1990 to 2003. N Engl J Med 2005;352:2515–23.
5. Hoffman C, Rice D, Sung HY. Persons with chronic conditions. Their prevalence and costs. JAMA 1996; 276:1473–9.
6. Simon GE, Katon WJ, VonKorff M, et al. Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. Am J Psychiatry 2001;158:1638–44.
7. Simon GE, VonKorff M, Barlow W. Health care costs of primary care patients with recognized depression. Arch Gen Psychiatry 1995;52:850–6.
8. Brown-Levey SM, Miller BF, deGruy FV. Behavioral health integration: an essential element of population-based healthcare redesign. Transl Behav Med 2012;2:364–71.
9. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. Health Aff (Millwood) 2008;27:759–69.
10. Petterson S, Phillips B, Bazemore A, Dodoo M, Zhang X, Green LA. Why there must be room for mental health in the medical home. Am Fam Physician 2008;77:757.
11. Callahan EJ, Bertakis KD, Azari R, Robbins JA, Helms LJ, Leigh JP. Association of higher costs with symptoms and diagnosis of depression. J Fam Pract 2002;51:540–4.
12. Ani C, Bazargan M, Hindman D, Bell D, Rodriguez M, Baker RS. Comorbid chronic illness and the diagnosis and treatment of depression in safety net primary care settings. J Am Board Fam Med 2009; 22:123–35.
13. Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the Chronic Care Model, part 2. JAMA 2002; 288:1909–14.
14. Hwang W, Weller W, Ireys H, Anderson G. Out-of-pocket medical spending for care of chronic conditions. Health Aff (Millwood) 2001;20:267–78.
15. Lurie IZ, Manheim LM, Dunlop DD. Differences in medical care expenditures for adults with depression

compared to adults with major chronic conditions. J Ment Health Policy Econ 2009;12:87–95.
16. Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic disease, and decrements in health: results from the World Health Surveys. Lancet 2007;370:851–8.
17. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. Milbank Q 1996;74:511–44.
18. Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. Arch Intern Med 2002;162: 2269–76.
19. The Center for Consumer Information and Insurance Oversight. Mental Health Parity and Addiction Equity Act (MHPAEA). Available from: http://cciio.cms.gov/programs/protections/mhpaea/index.html. Accessed December 1, 2012.
20. Baldwin LM, Patanian MM, Larson EH, et al. Modeling the mental health workforce in Washington State: using state licensing data to examine provider supply in rural and urban areas. J Rural Health 2006; 22:50–8.
21. Miller BF, Mendenhall TJ, Malik AD. Integrated primary care: an inclusive three-world view through process metrics and empirical discrimination. J Clin Psychol Med Settings 2009;16:21–30.
22. Phillps RL, Miller BF, Petterson SM, Teevan B. Better integration of mental health care improves depression screening and treatment in primary care. Am Fam Physician 2011;84:980.
23. Xierali IM, Tong ST, Petterson SM, Puffer JC, Phillips RL, Bazemore AW. Family physicians are essential for mental health care delivery. J Am Board Fam Med 2013;2:114–115.
24. Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977;196:129–35.
25. Substance Abuse and Mental Health Services Administration. Mental health, United States, 2010. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2012.
26. Butler M, Kane RL, McAlpin D, et al. Integration of mental health/substance abuse and primary care no. 173. Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290–02-0009. AHRQ Publication No. 09-E003. Rockville, MD: Agency for Healthcare Research and Quality; October 2008.
27. Collins C, Hewson DL, Munger R, Wade T. Evolving models of behavioral health integration in primary care. Milbank Fund Report. 2010. http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf.
28. Bird DC, Dempsey P, Hartley D. Addressing mental health workforce needs in underserved rural areas: accomplishments and challenges (working paper no. 23). Portland: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy, Maine Rural Health Research Center; 2011.
29. Fortney JC, Pyne JM, Edlund MJ, et al. A randomized trial of telemedicine-based collaborative care for depression. J Gen Intern Med 2007;22:1086–93.
30. American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). Joint principles of the patient-centered medical home. 2007. Available from: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.
31. Kessler R, Stafford D, Messier R. The problem of integrating behavioral health in the medical home and the questions it leads to. J Clin Psychol Med Settings 2009;16:4–12.
32. Rittenhouse DR, Shortell SM. The patient-centered medical home: will it stand the test of health reform? JAMA 2009;301:2038–40.
33. Dickinson WP, Miller BF. Comprehensiveness and continuity of care and the inseparability of mental and behavioral health from the patient-centered medical home. Fam Syst Health 2010;28:348–55.
34. Blount A. Integrated primary care: organizing the evidence. Fam Syst Health 2003;21:121–33.
35. Craven M, Bland R. Better practices in collaborative mental health care: an analysis of the evidence base. Can J Psychiatry 2006;51(Suppl 1):7S–72S.
36. Miller BF, Kessler R, Peek CJ, Kallenberg GA. A National Research Agenda for Research in Collaborative Care: papers from the Collaborative Care Research Network Research Development Conference. AHRQ Publication No. 11–0067. 2011. Available from: http://www.ahrq.gov/research/collaborativecare/. Accessed January 5, 2013.
37. deGruy FV, Etz RS. Attending to the whole person in the patient-centered medical home: the case for incorporating mental healthcare, substance abuse care, and health behavior change. Fam Syst Health 2010;28:298–307.
38. Kathol RG, Butler M, McAlpine DD, Kane RL. Barriers to physical and mental condition integrated service delivery. Psychosom Med 2010;72:511–8.
39. Mauch D, Kautz C, Smith SA. Reimbursement of mental health services in primary care settings. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2008. HHS Pub. No. SMA-08–4324.
40. Cunningham PJ. Beyond parity: primary care physicians' perspectives on access to mental health care. Health Aff (Millwood) 2009;28:w490–501.
41. Fisher L, Ransom DC. Developing a strategy for managing behavioral health care within the context of primary care. Arch Intern Med 1997;6:324–33.
42. Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA 2006;295:1023–32.