

The Evolving Role of Psychiatry in the Era of Health Care Reform

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Health care reform offers psychiatrists, who are trained in both general medical and behavioral health care, many opportunities to assume leadership roles on collaborative care teams and improve patient outcomes. This column describes such opportunities in primary care and public mental health settings and outlines new competencies, such as enhanced primary care skills, that will allow psychiatrists to expand their scope of practice in new models of care in the era of reform. These changes will require training, and the author calls on leaders of the American Psychiatric Association to help psychiatrists obtain new skills and undertake new roles. (*Psychiatric Services* 64:1076–1078, 2013; doi: 10.1176/appi.ps.201300311)

It's an optimistic time to be a psychiatrist in this country. As health care reform progresses to full realization in 2014 and the health care field turns its collective compass in the direction of the "triple aim," psychiatrists will have opportunities to collaborate with their medical colleagues to improve outcomes and cost efficiencies while enhancing patients' experience of care. Such collaborations have the potential to move the field of psychiatry to a new level of relevance. The psychiatrist of tomorrow will need to prepare for these changes by developing a broader set of competencies

and accepting a culture of shared accountability.

Coupled with these changes is a chance to provide expert guidance and leadership if psychiatrists embrace these opportunities and adequately position themselves at the forefront of this movement. Failure to do so at this important juncture places psychiatrists in a precarious position with their medical colleagues, who have a gap to fill to effectively treat mental illnesses. Psychiatrists have a foundational skill set that is distinct from those of other behavioral health disciplines. Their training in both the general medical and the behavioral health worlds makes them well situated to lead this effort. This column outlines the opportunities available—and the competencies necessary—to shift the role of psychiatry to accommodate the needs of the larger medical community in health care reform.

Areas of opportunity

Several emerging areas will benefit from the expertise of psychiatrists and their enhanced presence, particularly in the area of primary care. The potential for a mutually beneficial relationship between psychiatry and primary care exists, given the need in primary care settings for improving outcomes of treatments for mental illnesses and the need in public mental health settings for treating the medical conditions of the most vulnerable patients. In addition, it is clear that untreated mental illness accounts for substantial increases in overall health care costs (1) and drives the use of resources in the population of patients commonly referred to as "high utilizers." Although psychiatric service lines are rarely seen as revenue generators for a health care operation,

new systems that are held accountable for outcomes and cost containment will readily see the value of utilizing psychiatric expertise to contain costs while improving outcomes.

In primary care settings, it is essential for psychiatrists to become accessible and reliable consultants and to provide support to primary care providers. This may seem challenging given the shortage of psychiatrists, but it can be accomplished by collaborative care teams that are guided by the fundamental principles of the chronic care model (2), in which prepared and proactive teams provide optimal treatment. In the IMPACT approach (Improving Mood—Promoting Access to Collaborative Treatment) (3), an adaptation of the chronic care model, a consultant psychiatrist is available to the team for caseload review, "curbside" consultation, and education—and, less frequently, for direct evaluations. Working behind the scenes, the psychiatrist provides continuous input to the team in the primary care clinic, allowing extension of psychiatrists' expertise to a larger population of patients than is possible in one-to-one evaluations. Patients who are not responding to treatment at one level can be "stepped" to higher levels of care via this consultation model, and care can be quickly adjusted to ensure maximum treatment response. Primary care physicians can be encouraged to go beyond first- and second-line treatments, knowing that they are not alone and that psychiatric expertise is readily available. To be successful in this model, psychiatrists must embrace this team-based culture and the approaches used, manage and understand liability concerns in regard to consultations for patients whom they have not directly examined, be willing to

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consult across the life span if necessary, and be knowledgeable about HIPAA regulations to prevent misinterpretation and the risk of providers' not knowing what is in each other's charts.

In public mental health settings, there is a growing call for psychiatrists to be responsible for and prepared to assume greater medical oversight of the general medical care of their patients, particularly individuals with serious mental illnesses. At a minimum, psychiatrists are responsible for problems caused by psychiatric medications. Given the potential cardiovascular side effects of second-generation antipsychotics and other psychiatric medications, this principle is difficult to uphold while psychiatrists are also trying to control the potentially devastating and life-threatening symptoms of serious mental illnesses. However, psychiatrists need to acknowledge that these medications have contributed to worsening health outcomes and take responsibility for addressing the consequences.

A set of principles is emerging to guide care to offset some of the risks and help patients become healthier (4). These principles include minimizing the effects of medications, such as second-generation antipsychotics, by choosing those with less potential for harm. Although this may seem like a logical and often used approach, a recent study by Hermes and colleagues (5) showed that over 75% of patients with mental illnesses who had cardiometabolic disorders were receiving medications that presented a higher cardiometabolic risk than other similar medications.

Another important principle is to regularly screen patients for underlying chronic medical conditions and any worsening of illnesses resulting from the effects of medications. This includes use of tools such as the 2004 screening guidelines developed by the American Diabetes Association and the American Psychiatric Association for patients taking second-generation antipsychotics, which call for monitoring specific health parameters. Here again, discrepancies have been noted between psychiatrists' knowledge that screening is important and should occur regularly (6) and their screening practices (7). A third principle is the vital role that psychiatrists can play in

counseling their patients about lifestyle issues. From smoking cessation to exercise and diet, psychiatrists are experts in behavior change. Extending this expertise to lifestyle issues that threaten the health of patients is crucial.

A fourth and somewhat more intriguing principle is psychiatrists' treatment of some chronic general medical conditions when primary care services are not available to or utilized by patients. This will require retraining psychiatrists in general medical skills learned in medical school and residency as well as establishing a system of consultation with primary care colleagues. Finally, psychiatrists' training in the full range of medicine provides them with a unique skill set to successfully lead teams in models such as patient-centered medical homes and behavioral health homes. To be proficient leaders in these models, psychiatrists will have to develop new competencies and be willing to step forward and accept these roles. Doing so could enhance psychiatrists' relevance in public mental health settings as their overall skills in medicine become more valued on teams that must embrace whole-person care.

High utilizers of health care resources have recently been more prominently targeted for intervention, and the practice of "hot spotting" to identify them has become more widespread. Psychiatrists' roles in working with this patient cohort include being proactive in the identification and treatment of mental illnesses that can contribute to complex health conditions and the excessive use of medical services. Areas in which such intervention may be valuable include primary care clinics, emergency rooms, and community mental health centers, where some of the high utilization is linked to serious mental illnesses. Inpatient units can undertake interventions such as proactive consultation-liaison services (8) to break the cycle of poor outcomes by identifying behavioral health comorbidity.

New competencies for psychiatrists

Enhanced primary care skills will be essential for a multitude of reasons, including the need to restore psychiatrists' confidence in communicating

with medical colleagues and to better prepare psychiatrists to review targeted nonpsychiatric outcomes. This knowledge will be helpful in using the new CPT coding system accurately and in addressing growing concerns about cardiovascular risk among patients with serious mental illnesses. Improving psychiatrists' knowledge about the most effective treatments for common general medical conditions could also lead to psychiatrists' providing some basic general medical care.

The move toward provision of basic treatments for common medical conditions in the psychiatrist's office has gained momentum recently for many reasons, including a lack of available primary care services and some patients' reluctance to seek care outside the mental health setting. Individuals with serious mental illnesses are substantially burdened by medical conditions. Their alarming mortality gap and their need for primary care services are well known. Psychiatrists' training in medicine will enable them to work to expand their scope of practice to once again embrace a more inclusive approach to medicine. A decade of screening and referral to primary care services has done little to move the dial on the mortality gap. Some have raised concerns that screening patients and not providing care for identified conditions may one day be more difficult to defend than attempting to provide this care by expansion of the psychiatrists' scope of practice.

Such expansion will require specific retraining, consultation, and guidance from professional organizations to be effective and accepted as an additional area of competence for psychiatrists who are willing and interested. "Consultant" and "embedded" primary care providers have been introduced in health home initiatives in Missouri and Ohio, and on-site primary care providers are employed in the Primary and Behavioral Health Care Integration grantee locations. These colleagues, whose roles in such systems mirror the roles that psychiatrists play on collaborative teams in primary care, can offer advice and guidance. Primary care providers can help raise psychiatrists' confidence in their general medical skills. One

previous study demonstrated the confidence that psychiatrists could be an appropriate treatment provider for a list of chronic conditions (9).

Practicing population-based care will be another essential competency as the focus shifts to assuming responsibility for a defined population of patients who are tracked in registries and monitored for progress and adequate follow-up. The care is more proactive than reactive, with a focus more on the denominator (all patients who need care) than on the numerator (those who request care). Utilizing population-level metrics helps establish priorities and adjust interventions to lead to better outcomes. Because of the health disparities experienced by individuals with serious mental illnesses, psychiatrists need to begin tracking specific health indicators and using knowledge obtained from these aggregate data to identify care gaps and determine a best course for intervention. Psychiatrists will need to know which illnesses to focus on, which metrics to use, and how to identify and treat patients who are high utilizers.

Using data to drive care will become even more essential as outcome measurements play a role in determining how payment is obtained for services. Utilizing a “treat-to-target” approach for both mental and general medical illnesses will be essential as predetermined goals are set and the team works to ensure that adequate treatment is provided, timely follow-up ensues, and adjustments are made if the patient is not making progress. This approach can be taken by psychiatrists to monitor treatment of depression in their practice; for example, they can make serial use of the Patient Health Questionnaire, with a goal of lowering the score to less than 5 points. Or they can follow a cohort of patients with serious mental illness and comorbid diabetes, seeking to reduce HbA1c levels to

less than 7% among at least 60% of the cohort. Outcome data will be an important driver of system design and payment for services in a reformed health care system, and psychiatrists will need to acknowledge their accountability in this process.

Leadership skills will be necessary to guide teams in merging the cultures of primary care and behavioral health care, which have been siloed for decades. With one foot in behavioral health and the other in the rest of medicine, psychiatrists are in a unique position to span the gap between the two and work to reduce the resistance inherent in the process. Confidence, humility, and competence will guide this process, and successful leaders will seek to improve their knowledge and understanding of team dynamics and team-building strategies.

Conclusions

Health care reform presents many opportunities for psychiatrists to play key roles. Psychiatrists can be catalysts for change in the rapidly changing health care environment due in part to their unique training in the full spectrum of medicine, their expertise in behavior change, and their knowledge of group dynamics and team participation. This evolution will require training, and leaders of the American Psychiatric Association should heed the call, helping psychiatrists to obtain new skills and formally supporting them as they prepare to undertake new roles. For psychiatrists who are already working in new health care venues, the experience has been exciting and rewarding. We can build on this enthusiasm with medical students and residents and give the next generation of psychiatrists an opportunity to have a greater population-level impact by leveraging their skills in a different way. As a profession,

now is the time to choose to “go where the ball is heading.”

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